CCME

2017 External Quality Review

WELLCARE OF SOUTH CAROLINA

Submitted: January 18, 2018

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The purpose of this review was to determine the level of performance demonstrated by WellCare of South Carolina (WellCare) since the 2016 Annual Review. This report contains a description of the process and the results of the *2017 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Review goals include the following:

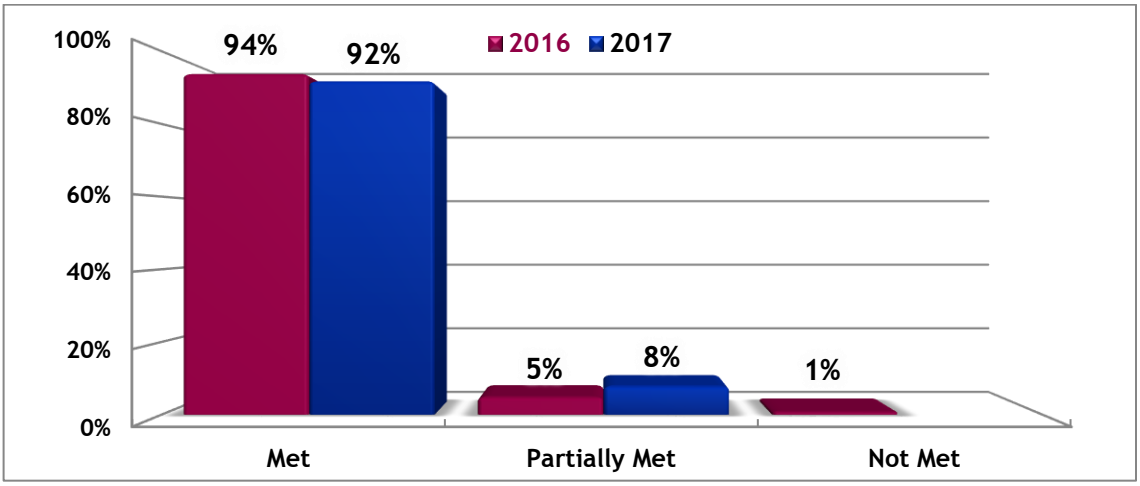
- Determine if WellCare followed service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2016 Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Assure that contracted health care services are being delivered and are of good quality

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review included a desk review of documents, a two-day onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects (PIPs), validation of performance improvement measures, and validation of satisfaction surveys.

Overall Findings

The 2017 annual EQR shows that WellCare achieved a “Met” score for 92% of the standards reviewed. The following chart compares WellCare’s current review results to the 2016 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items and recommendations can be found further in the narrative of this report.

Administration:

WellCare's policies and procedures are well-organized and staff review and update polices annually. The organizational chart shows appropriate lines of authority and responsibility. Vacant positions noted on the organizational chart are either filled or recruitment is underway.

The WellCare Corporate Compliance Program is in place and includes appropriate training for the Plan President, directors, providers, employees, and external vendors. Fraud, waste, and abuse hotline phone numbers are documented in the Provider Manual, Member Handbook, and the WellCare website. Fraud, waste, and abuse hotline phone numbers are also included in employee information.

WellCare's Information System Capabilities Assessment (ISCA) Audit documentation demonstrated the health plan meets the organization's internal requirements and surpasses the MCO contract requirements for claims processing. The MCO provided comprehensive materials detailing their procedures, which follow Health Insurance Portability and Accountability Act (HIPAA) standards and practices. WellCare provided documentation detailing an extensive and thorough Disaster Recovery/Business Continuity (DR/BC) Plan. Testing of the Plan was performed from February 27, 2017 to March 2, 2017, and was successful.

Provider Services:

The Credentialing Committee (CC) meets monthly and is chaired by Dr. Robert London, Sr. Medical Director. Other committee voting members include four network physicians with the specialties of cardiology, hematology/oncology, family medicine, and pediatrics, and a licensed clinical social worker representing behavioral health. Onsite discussion confirmed a quorum is met with two voting members plus the committee chair. Corporate Medical Directors review and approve clean files. The local CC reviews and approves all other files.

Issues relating to the Credentialing Program included policies that contained outdated references to retired procedures; the policy addressing ongoing monitoring did not address querying the Exclusion and Termination for Cause List or the Social Security Death Master File (SSDMF); querying the Exclusion and Termination for Cause List is not mentioned in any of the credentialing policies or documents, and is not evident in the credentialing/recredentialing files. Additional file review issues included hospital admitting arrangements not being addressed for Licensed Professional Counselors. One file had an outdated Ownership Disclosure form.

CCME identified inconsistencies between documents for some of the appointment access standards, and the Appointment Availability & Accessibility Timely Access Report lacked detailed analysis.

Member Services:

Members receive a Member Handbook and other new member materials within 14 days after receipt of enrollment information from SCDHHS. The Member Handbook is available on the WellCare website along with a change control log to document updates or changes to the handbook. The Member Handbook contains most contractually-required information; however, CCME recommends that the Member Handbook indicate substance abuse treatment services provided by South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) and its subcontracted 33 county alcohol and drug abuse authorities are covered.

Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey response rates continue to decline. The response rate for the 2017 survey fell to 13% (Child) and 17.7% (Adult), representing a continued decline from 2015. CCME offered suggestions for measures to try to increase the response rates for future surveys. WellCare plans to distribute the 2017 CAHPS survey results to its network providers via the Provider Newsletter for Quarter 4 of 2017. No evidence was found that the full CAHPS results and resulting action plans were reported to the Quality Improvement Committee (QIC), but WellCare staff indicated a work group is in development and a rapid cycle PIP is in

progress to address CAHPS scores. WellCare plans to present full CAHPS results during the next QIC meeting.

A review of documented grievance processes and requirements revealed several issues, including inaccurate terminology in the definition of a grievance, incorrect documentation of the timeframe to file a grievance, errors in documentation of grievance resolution timeframes, and incomplete documentation of requirements for member notification of plan-initiated grievance resolution timeframe extensions. Grievance files revealed Acknowledgement letters and Notice of Resolution letters sent beyond the allowed timeframes, missing Acknowledgement letters, and undated Request for Information letters.

Quality Improvement:

WellCare's 2017 Medicaid Quality Improvement Program Description describes the structure, resources and processes used for measuring and improving care and services. The program description outlines the QI Program goals, objectives, and scope. The Utilization Management Medical Advisory Committee (UMAC), QIC, and the Board of Directors review and approve the program description.

WellCare uses Quality Spectrum Insight (QSI) by Inovalon, a certified software organization, to calculate Health Effectiveness Data Information Set® (HEDIS) rates and verify the measures follow CMS protocol requirements. The previous-to-current-year comparison revealed a strong increase in follow up after hospitalization for mental illness for both the 30-day and 7-day rates. The measures that decreased substantially are Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) and Statin Therapy for Patients with Cardiovascular Disease (spc), Statin Adherence at 80%. WellCare should evaluate changes in rates that are not going in the intended direction, and develop and document specific quality improvement plans to increase or decrease rates as intended.

CCME validated two projects using the CMS Protocol for Validation of Performance Improvement Projects. They included Access to Care and Improving Hemoglobin A1C Testing. Both projects scored within the High Confidence Range and met the validation requirements.

Utilization Management:

WellCare's 2017 Utilization Management (UM) Program Description and UM policies define UM requirements and guide staff in the performance of UM functions. CCME noted several issues in documentation within the policies and/or program description, and offered suggestions for improvement.

UM approval and denial files confirmed timely determinations, requests for additional clinical information when needed, and use of appropriate criteria. However, several Notice of Adverse Benefit Determination letters did not specify the criteria used to review the services for which authorization was requested.

WellCare has policies in place to guide staff in the handling and processing of appeals. CCME noted minor, easily correctable issues in the appeals policies. However, Policy SC22-RX-012, Pharmacy Appeals, is not specific to SC requirements. Although there is a table at the end of the policy to define SC requirements, the information in the table is incomplete.

Case Management (CM) and Care Transitions processes are documented in the Care Management Program Description and in policies. Overall, the program description and policies contain most of the information necessary to understand and perform CM functions; however, the Care Management Program Description and policies do not define the CM services provided to members for each of the defined acuity levels and do not include the full scope of diagnoses for which targeted CM referrals are indicated.

Of note, prior authorization files revealed nurses check various databases (System for Award Management [SAM], Office of Inspector General [OIG] List of Excluded Individuals & Entities [LEIE], and SC Excluded Providers List) and include documentation of results in the file when authorizing out of network care.

Delegation:

WellCare has written agreements with all entities performing delegated services and an extension delegation oversight process. However, in reviewing the delegation oversight documents, CCME discovered the following issues:

- Inconsistent or incomplete information
- Out-of-state providers (i.e. Georgia) that see SC members do not appear to be credentialed/recredentialed to SC requirements
- Ownership Disclosure forms and Clinical Laboratory Improvement Amendment (CLIA) certificates do not appear to always be collected as required

State Mandated Services:

WellCare provides all core benefits required by the *SCDHHS Contract*. Appropriate processes are in place to ensure provider compliance with member monitoring and tracking. Follow up activities for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are in place, including random Medical Record Review (MRR) Audits. The MRR Audit results are provided in writing and the provider may obtain clarification from

WellCare staff if needed. Providers who do not successfully pass the MRR are automatically selected for MRR during the subsequent review cycle.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2016 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2016	32	1	0	0	0	33
2017	39	0	0	0	0	39
Provider Services						
2016	70	4	1	0	0	75
2017	71	7	0	0	0	78
Member Services						
2016	35	2	0	0	0	37
2017	30	3	0	0	0	33
Quality Improvement						
2016	15	0	0	0	0	15
2017	15	0	0	0	0	15
Utilization						
2016	35	3	0	0	0	38
2017	39	6	0	0	0	45
Delegation						
2016	1	1	0	0	0	2
2017	1	1	0	0	0	2
State Mandated Services						
2016	4	0	0	0	0	4
2017	4	0	0	0	0	4

METHODOLOGY

The process used by CCME for the EQR was based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally mandated EQR activities:

- Compliance determination
- Validation of performance measures
- Validation of performance improvement projects

On October 23, 2017, CCME sent notification to WellCare that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow WellCare to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from WellCare on November 6, 2017 and reviewed in CCME offices (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on December 19, 2017 and December 20, 2017 at the WellCare office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with administration and staff; and an exit conference. CCME invited all interested parties to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following table and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between WellCare and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. We identify areas of review as meeting a standard “Met,” acceptable but needing improvement “Partially Met,” failing a standard “Not Met,” “Not Applicable,” or “Not Evaluated,” on the tabular spreadsheet (Attachment 4).

A. Administration

WellCare's policies and procedures are in one document with the policy listed first, followed by the corresponding procedure. The master list of policies and procedures is well organized and shows effective dates, review dates, revision dates, and the scheduled review date. Reviews are completed annually. The annual review process is electronic in Compliance 360 with a point person managing the process. WellCare notifies staff of any changes to policies via email.

Kathy Warner, WellCare's Plan President, leads the leadership team and provides day-to-day oversight of business activities. The Vice President, Regional Financial Officer is Jeff Skobel. The Senior Director of Finance is noted as an open position. According to staff, this position was recently filled. The Director of State Regulatory Affairs is noted as a vacant position on the organizational chart. However, this position was recently filled by Mark Ruise. WellCare's Senior Medical Director is Dr. Robert London. Dr. London is board certified in OB/GYN, licensed in SC, and oversees the clinical functions of the organization.

The organizational chart is well organized and shows lines of authority and responsibility. Throughout the organization there were nine open or vacant positions listed on the organizational chart. Recruiting for the vacant positions was underway with some recently filled or offers pending.

The WellCare Corporate Compliance Program is in place, and includes appropriate training for the Plan President, directors, providers, employees, and external vendors. The Market Compliance Committee is the local committee established to provide local oversight of the compliance program in SC. This committee meets quarterly. Good attendance and quorums were documented in the minutes of each committee meeting. Fraud, waste, and abuse hotline phone numbers are documented in the Provider Manual, Member Handbook, and the WellCare website. Fraud, waste, and abuse hotline phone numbers are also included in employee information.

WellCare's ISCA documentation states that claims are monitored for timeliness and accuracy. The health plan meets the organization's internal requirements and surpasses the MCO contract requirements by completing 99.72% of claims in 30 days and 99% within 90 days. The MCO provided comprehensive materials detailing their procedures which follow HIPAA standards and practices. The documentation states that WellCare accepts and generates HIPAA-compliant electronic transactions.

WellCare provided documentation detailing an extensive and thorough Disaster Recovery/ Business Continuity plan. Testing of the plan was performed from February 27, 2017 to March 2, 2017, and was successful except for "no significant findings and one minor procedural audit." The test was based on the scenario of experiencing a Category 5

hurricane. With recent DR improvements, the results demonstrate WellCare's DR plan exceeds the SCDHHS Contract requirements. WellCare's Internal Audit Team indicated their intention to continue to refine and advance the DR process.

WellCare received "Met" scores for 100% of the standards in the Administration section as noted in *Figure 2 Administration Findings*.

Figure 2: Administration Findings

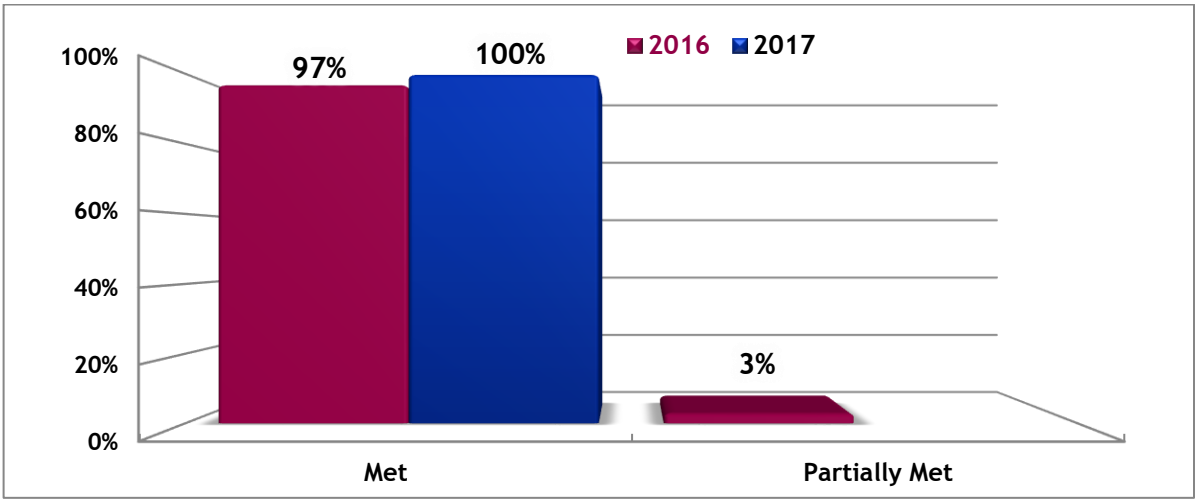


Table 2: Administration Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Management Information Systems	The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Thorough documentation regarding system security practices, workflows and processes.
- WellCare surpasses the timeliness requirements for processing claims.

B. Provider Services

CCME conducted a review of all Provider Services policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing/recredentialing files, and practice guidelines. The CC meets monthly and is chaired by Dr. Robert London, Sr. Medical Director. Other voting members of the committee include four network physicians with the specialties of cardiology, hematology/oncology, family medicine, and pediatrics, and a licensed clinical social worker representing behavioral health. Onsite discussion confirmed a quorum is met with two voting members plus the committee chair. Corporate Medical Directors review and approve clean files. The local CC reviews and approves all other files.

Credentialing and recredentialing is addressed in the corporate Credentialing Program Description and Policy SC22 HS-CR-001, South Carolina – Credentialing and Re-credentialing. Additional policies address various processes or guidelines related to the Credentialing Department. Many of the policies contained outdated references to retired procedures that were merged into an applicable policy. In addition, the Exclusion and Termination for Cause List is not mentioned in any of the credentialing policies or documents. Onsite discussion confirmed the list is being reviewed in WellCare's processes; however, it was not considered a credentialing function. The credentialing and recredentialing file review showed no evidence of query of the Exclusion and Termination for Cause List. Other credentialing/recredentialing file review issues included not collecting hospital admitting arrangements for licensed professional counselors and one recredentialing file had an outdated Ownership Disclosure form. The policy addressing ongoing monitoring did not address querying the Exclusion and Termination for Cause List or the SSDMF.

CCME received and reviewed GeoAccess reports which showed that WellCare used correct standards for measuring network access. WellCare has a solid network with access that exceeds contract requirements. For appointment availability, inconsistencies were identified between documents for some of the appointment access standards. In addition, the Appointment Availability & Accessibility Timely Access Report lacked detailed analysis.

Provider Access and Availability Study

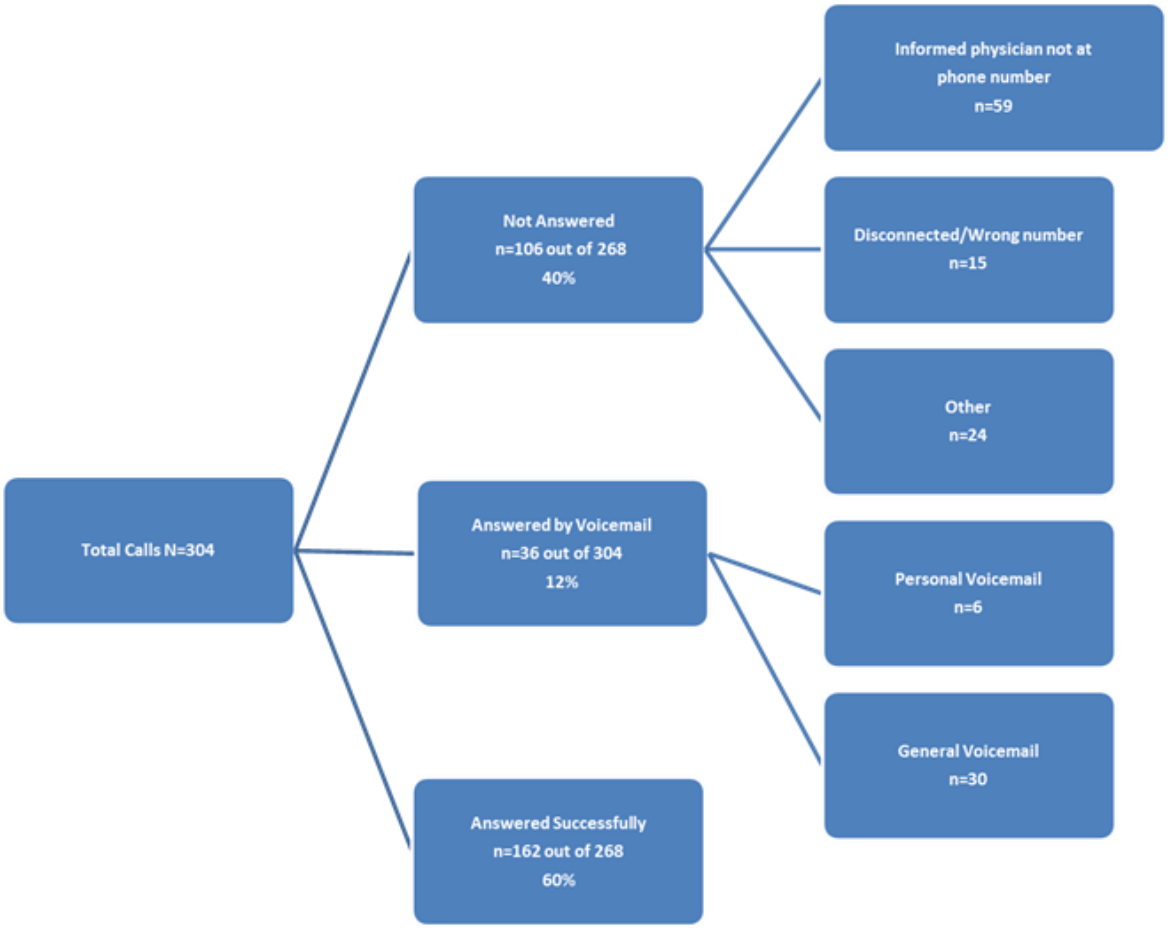
As part of the annual EQR process for WellCare, CCME performed a Telephonic Provider Access Study focusing on primary care providers (PCPs). WellCare provided a list of current providers to CCME. From the list, a population of 1,858 unique PCPs was found. A sample of 304 providers were randomly selected from this population for the Telephonic Provider Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

Table 3: Telephone Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact P-value
2016 Review	298	42%	<.01
2017 Review	304	60%	

In reference to results of the Telephonic Provider Access Study, conducted by CCME, calls were successfully answered 60% of the time (162 out of 268) when omitting calls answered by personal or general voicemail messaging services (*see Figure 3*).

Figure 3: Telephonic Provider Access Study Results



When compared to last year's results of 42%, this year's study had a statistically significant increase in successful calls (p<.01).

For those not answered successfully (n=142 calls), 59 (42%) were unsuccessful because the provider was not at the office or phone number listed. Of the 162 successful calls, 132 out of the 156 providers that responded to the question (85%) of the providers indicated that they accept WellCare health plan, although five (3%) indicated that this occurred only under certain conditions. And of the 132 that accept WellCare health plan, 104 (79%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 42 (41%) of the 102 providers that responded to the item indicated that an application or prescreen was necessary. Of those 42, 13 (31%) indicated that an application must be filled out whereas 8 (19%) require a review of medical records before accepting a new patient, and 13 (31%) required both. When the office was asked about the next available routine appointment, 73 (73%) of the 99 responses met contact requirements.

Figure 4, *Provider Services Findings* shows that 91% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings

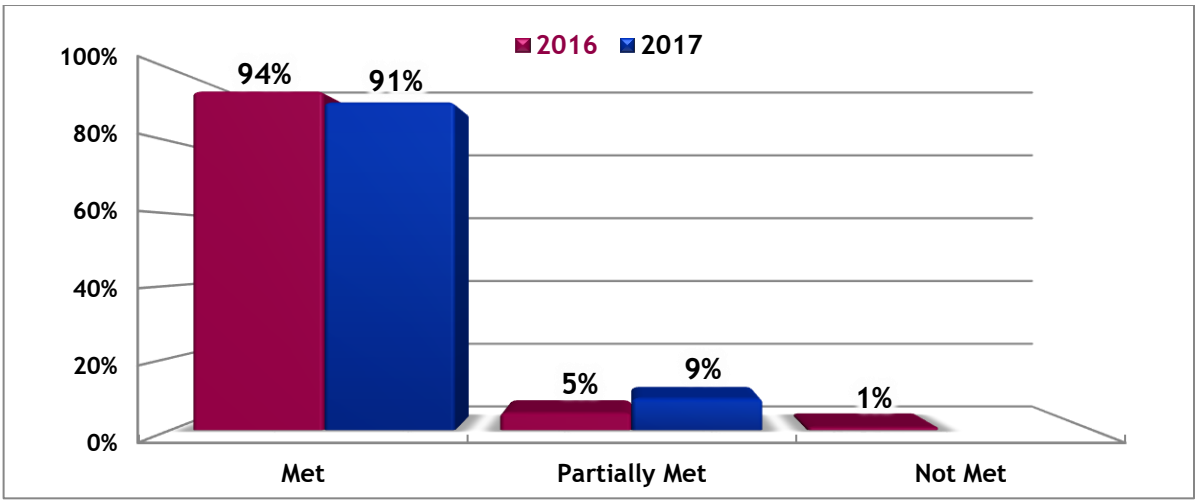


Table 4: Provider Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Partially Met	Met
	Credentialing: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Partially Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Partially Met
	Recredentialing: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Partially Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Partially Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Partially Met
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Partially Met	Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Met
Practitioner Medical Records	The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Telephonic Provider Access Study success rates increased with the new calculation formula for success rate.
- In 2017, WellCare improved the website provider portal with streamlined tools including comprehensive member profile, improved authorization and claim submission, more ways to communicate electronically (secure messages and online chat), more robust data and reports, and practice management (update demographic information, select communication preferences, manage users, etc.)

Weaknesses

- The Exclusion and Termination for Cause List is not mentioned in any of the credentialing policies or documents. It is listed as a requirement in the *SCDHHS Policy and Procedure Guide, Sections 11.1.21* and *11.2*. Onsite discussion confirmed that WellCare reviews the list is in their processes; however, it was not considered a credentialing function.
- Many of the policies still reference Procedure SC22 HS-CR-001-PR-001 which was retired and merged into Policy SC22-HS-CR-001. Examples include the following:
  - Page 32 of SC22-HS-CR-001
  - Page 1 of SC22-HS-CR-004
  - Page 2 of SC22-HS-CR-010
  - Pages 1 and 2 of SC22-HS-CR-016
  - Page 6 of SC22-CP-AO-007
  - Page 9 of SC22-CP-AO-007-PR-001
- Page 10 of Policy SC22-CP-AO-007-PR-001 references Procedure SC22 HS-CR-046-PR-001 which was retired and merged into Policy SC22-HS-CR-046.
- The 2017 Credentialing Committee Members-Internal and External list incorrectly shows Mark DaShiell as a voting member of the committee.
- The following was identified in the credentialing and recredentialing file reviews:
  - Credentialing and recredentialing files did not contain evidence that the Exclusion and Termination for Cause List was queried.
  - Two credentialing files for licensed professional counselors did not address hospital admitting arrangements. Onside discussion confirmed that WellCare does not pursue hospital admitting arrangements for licensed professional counselors

  - One recredentialing file had an Ownership Disclosure form signed 9/8/15 when the CC approval was 5/15/17. Onsite discussion confirmed the Plan seeks to obtain updated forms from providers but after three attempts, they do not pursue it.

- Page 12 of Policy SC22 HS-CR-009, SC - Assessment of Organizational Providers, has the following statement that is no longer applicable per onsite discussion, "An initial onsite review is required of all Primary Care Physicians and OB/GYN physicians acting as Primary Care Physicians, prior to the completion of the initial credentialing process."
- Policy SC22 HS-CR-046, SC Ongoing Monitoring of Providers, does not address querying the Social Security Death Master File (SSDMF) or the Exclusion and Termination for Cause List.
- Policy SC22 OP-NI-003, SC- Provider Directory Production, defines the minimum information listed in the Provider Directory and it appears to be missing "office hours."
- CCME identified access standard inconsistencies between documents as follows:
  - Behavioral health routine care is listed as "less than 10 days" in the Member Handbook and Provider Manual; listed as "<= 10 business days" in the Timely Access Report; and listed as "less than 10 business days" in Policy SC22 OP-NI-002.
  - Page 24 of the Provider Manual states PCP routine/wellness visits as "within 4 to 6 weeks" when all other documents list it as "within 4 weeks."
  - The Provider In-Service Checklist states the following incorrect timeframes for availability, "Urgent, 1 day: Routine 1 week: Preventative 1 month."
- The Appointment Availability & Accessibility Timely Access Report lacked information such as how the audit was conducted (phone calls to providers?), defined goals for the access standards, analysis as to whether the access standard goals were met, interventions to address low results, and outcome of follow-up for non-compliant providers.

Quality Improvement Plans

- Address WellCare's process for ensuring the Exclusion and Termination for Cause List is reviewed at initial credentialing, recredentialing, and monthly in appropriate policies and documents.
- Update identified policies to remove the incorrect references to retired procedures.
- Include evidence of query of the Exclusion and Termination for Cause List in credentialing and recredentialing files.
- Ensure hospital admitting arrangements are addressed for all providers during the credentialing process.

- Update Policy SC22 HS-CR-009, SC - Assessment of Organizational Providers to include the Exclusion and Termination for Cause List as a required query and ensure credentialing/recredentialing files contain proof of query.
- Remove the statement from Policy SC22 HS-CR-009 regarding onsite visits at initial credentialing that is no longer applicable.
- Update Policy SC22 HS-CR-046, SC Ongoing Monitoring of Providers to address queries of the SSDMF and the Exclusion and Termination for Cause list for monthly monitoring.
- Correct the inconsistencies regarding provider access standards in the Member Handbook, Provider Manual, Policy SC22 OP-NI-002, and the Provider In-Service Checklist.

Recommendations

- Update the 2017 Credentialing Committee Members-Internal and External list to show the correct voting members of the committee.
- WellCare should ensure they obtain updated Ownership Disclosure forms as required.
- Update Policy SC22 OP-NI-003, SC- Provider Directory Production to include "office hours" in the list of minimum information that is required to be included in the Provider Directory.
- Improve analysis of the Appointment Availability & Accessibility Timely Access Report. In addition, assess barriers and implement interventions to address the low results of the PCP and specialty (including behavioral health) accessibility surveys.

C. Member Services

WellCare's Member Services Call Center is in SC and normal business hours are Monday – Friday from 8 a.m. to 6 p.m. The toll-free telephone number for the Call Center is documented throughout the Member Handbook and in other plan materials. Outside of normal operating hours, members can leave a message for Member Services and receive a response within one business day. Members may also speak with the Nurse Help Line 24 hours a day, seven days a week.

WellCare provides a Member Handbook and other materials to new members no later than 14 days after receipt of enrollment information from SCDHHS. The Member Handbook is also available on the WellCare website along with a change control log to document updates or changes to the Member Handbook. The Member Handbook provides sufficient information for a new member to navigate the health plan and to understand benefits, services, and member rights and responsibilities. CCME recommends that WellCare update the Member Handbook to include that substance abuse treatment services provided by DAODAS (and its subcontracted 33 county alcohol and drug abuse authorities) are covered.

Policy SC22-SM-004, Medicaid Written Member Materials and Marketing Materials Review and Approval Process, as well as onsite discussion, confirms member materials are written at no higher than 6th grade reading level, but the Policy does not define the methods used to determine reading level. WellCare staff indicated during onsite discussion the Flesch-Kincaid method is used. CCME encourages WellCare to update Policy SC22-SM-004 to include this information.

A certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, SPH, conducts WellCare's annual Member Satisfaction Surveys. Compared to 2016, survey response rates declined from 18.6% to 13% (Child) and from 25% to 17.7% (Adult). This represents a continued decline from 2015 to 2017. CCME offered recommendations to try to increase the response rates for future surveys. Evidence of analysis, discussion, and development of initiatives to address problematic areas of member satisfaction are found in the CAHPS Analysis SC CAID 2017 document and in the Medicaid Program 2016 Annual Evaluation document. At the time of the onsite visit, WellCare had not distributed the 2017 CAHPS survey results to its network providers, but indicated they would be included in the Provider Newsletter for Quarter 4 of 2017. No evidence was found that the full CAHPS results and resulting action plans were reported to the QIC; however, WellCare indicated a work group is in development to focus on CAHPS scores and a rapid cycle PIP to address CAHPS scores is in progress. Staff indicated the results will be presented during the next QIC meeting.

A review of documented grievance processes and requirements, as well as grievance files, revealed several issues. The Medicaid Grievance Policy (SC22 OP-GR-001) and the Provider Manual define a grievance as an expression of dissatisfaction about any matter other than an action. However, the terminology in the SCDHHS Contract and in Federal Regulations has been changed from "action" to "adverse benefit determination." CCME encourages WellCare to update documentation accordingly. Several documents incorrectly state there is a limit on the time allowed to file a grievance, but Federal *Regulation § 438.402 (c) (B) (4) (ii) (2)* and the *SCDHHS Contract, Section 9.1.1.2.1* allow a grievance to be filed at any time. CCME noted errors in documentation of requirements surrounding grievance resolution timeframes and member notification of plan-initiated grievance resolution timeframe extensions. Issues identified in the grievance files reviewed included:

- Two files had Notice of Resolution letters sent beyond the allowed timeframe
- Three files had Acknowledgement letters sent after the allowed 5-business day timeframe
- Three files contained no evidence of Acknowledgement letters

- Two files contained letters requesting additional information that were not dated, yet informed the recipient the information was needed "within 10 days of the date of this letter"

As noted in the following chart, 91% of the standards for Member Services received a score of "Met." Scores of "Partially Met" are described in the Weaknesses section that follows.

Figure 5: Member Services Findings

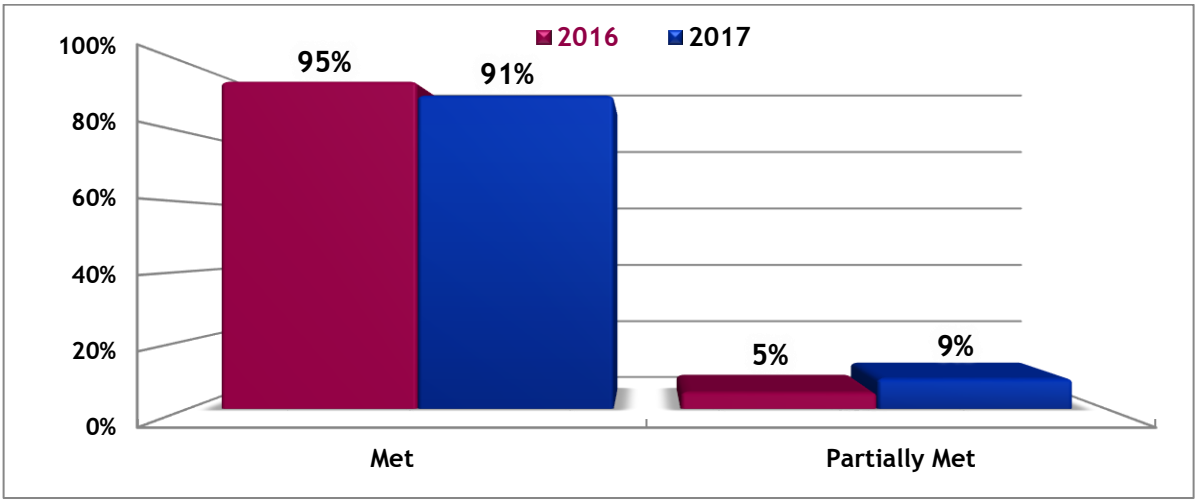


Table 5: Member Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information	Partially Met	Met
	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Partially Met	Met
Grievances	The procedure for filing and handling a grievance	Met	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Grievances	Timeliness guidelines for resolution of the grievance as specified in the contract	Met	Partially Met
	The MCO applies the grievance policy and procedure as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- The New Member Quick Tips webpage provides a brief overview of information new members will need to fully use their WellCare benefits and services.
- WellCare's Community Assistance Line (CAL) connects both members and non-members to community services such as utility assistance, food banks, transportation, rental assistance, and free and reduced-cost child care. Staff are available Monday-Friday, 9 a.m. to 6 p.m., and the CAL offers video relay chat.

Weaknesses

- Onsite discussion confirmed WellCare covers substance abuse treatment services provided by DAODAS; however, the Member Handbook does not mention that substance abuse treatment services provided by DAODAS (and its subcontracted 33 county alcohol and drug abuse authorities) are covered.
- Policy SC22-PD-002, Covered Service Policy, addresses notifying members at least 30 days prior to the discontinuation or modification of an additional service, but the policy does not address member notification of changes to the core benefits or services.
- Policy SC22-SM-004, Medicaid Written Member Materials and Marketing Materials Review and Approval Process, indicates all materials are written at a grade level no higher than the 6th grade or as determined appropriate by SCDHHS, but the Policy does not define the methods used to determine the reading level.
- Disease Management Programs in the Member Handbook include Asthma, Diabetes, CAD, CHF, COPD, Hypertension, Smoking Cessation, and Weight Management. However, the Provider Manual and the Disease Management Program Description also include Depression as a Disease Management Program. The Member Handbook states

depression is handled under the Case Management Program rather than the Disease Management Program.

- The Member Satisfaction Survey response rates decreased from the previous year's survey. The Adult survey response rate decreased by 7%, from 25% last year to 17.7% this year. The Child survey response rate decreased by over 5%, from 18.6% last year to 13% this year. The rates have continued to decline from 2015 to 2016 to 2017.
- QIC meeting minutes did not include a discussion of the full 2017 CAHPS results and actions plans based on those results.
- Policy SC22 OP-GR-001, Medicaid Grievance Policy, and the Provider Manual use the term "action" in the definition of a grievance. Refer to the *SCDHHS Contract, Section 9.1 (a)*.
- *Federal Regulation § 438.402 (c) (B) (4) (ii) (2)* and the *SCDHHS Contract, Section 9.1.1.2.1* allow a grievance to be filed at any time. However, the Member Handbook, page 50, and the WellCare website state grievances can be filed within 30 calendar days of the event that caused the dissatisfaction.
- The *SCDHHS Contract, Sections 9.1.6.1.5.1* and *9.1.6.1.5.2*, defines requirements for member notification when the health plan extends the grievance resolution timeframe. However, the Provider Manual and WellCare website do not address the requirement for oral and written notification to the member when the plan initiates an extension of the appeal resolution timeframe.
- The *SCDHHS Contract, Section 9.1.6.1.1*, requires grievances to be resolved no later than 90 calendar days from the date the grievance is received. However, the Grievance Acknowledgement letter incorrectly states the grievance resolution and notification timeframe is within 60 days of receiving the grievance.
- The following issues were identified in grievance files:
  - Two Notice of Resolution letters were sent beyond the allowed timeframe
  - Three Acknowledgement letters were sent after the allowed 5-business day timeframe
  - Three files contained no evidence of Acknowledgement letters
  - Two files had undated Additional Information letters that were not dated, yet the body of the letter stated the information was needed "within 10 days of the date of this letter"

Quality Improvement Plans

- Revise the Member Handbook and the WellCare website to reflect the correct timeframe for filing a grievance.

- Update the Provider Manual and WellCare website to indicate members will be notified orally and in writing when the plan initiates an extension of the grievance resolution timeframe.
- Correct the grievance resolution and notification timeframe in the Grievance Acknowledgement letter.
- Ensure grievance Acknowledgement and Resolution letters are sent within the required timeframes, that each grievance is acknowledged, and that Additional Information letters are dated.

Recommendations

- Update the Member Handbook to include that substance abuse treatment services provided by DAODAS (and its subcontracted 33 county alcohol and drug abuse authorities) are covered.
- Revise Policy SC22-PD-002, Covered Service Policy, to indicate members will be notified at least 30 days prior to discontinuation or modification of core benefits and services.
- Revise policy SC22-SM-004, Medicaid Written Member Materials and Marketing Materials Review and Approval Process, to include the method(s) used to determine reading level of member materials.
- Revise the Member Handbook to include depression as a Disease Management Program instead of a Case Management Program.
- Continue working with SPH or other chosen vendor to increase Member Satisfaction Survey response rates. Possible interventions for increasing response rates include adding reminders to call center scripts, placing a stamp on initial and follow-up mail outs, maximizing the oversampling, and allowing a longer timeline for additional reminders to be sent and phone call surveys to be conducted. CCME encourages WellCare to decide upon and document an internal goal to increase response rates (such as a 3% increase each year).
- Ensure complete CAHPS results are presented to the QIC.
- Replace the term “action” with the term “adverse benefit determination” throughout Policy SC22 OP-GR-001, Medicaid Grievance Policy, and the Provider Manual. Refer to the *SCDHHS Contract, Section 9.1 (a)*.

D. Quality Improvement

WellCare's 2017 Medicaid Quality Improvement Program Description describes the structure, resources, and processes used for measuring and improving care and services. The program description outlines the QI Program's goals, objectives and scope. The UMAC, QIC and the Board of Directors review and approve the program description.

The QI Program Description does not address monitoring of provider compliance to the clinical practice guidelines and preventive health guidelines. However, Policy SC22 HS-QI-009, South Carolina – Provider Clinical Practice Guidelines and Preventive Health Guidelines, addresses annual monitoring. At the onsite, WellCare provided CCME with a sample of the monitoring they conducted.

WellCare's Board of Directors delegates the authority to approve specific QI activities to the QIC. Oversight of all clinical quality improvement, utilization management, and behavioral health activities is the primary responsibility of the UMAC. WellCare's Medical Director, Dr. Robert London, chairs the QIC and the UMAC. Membership for the QIC includes senior leadership and other health plan directors and managers. The UMAC members include network providers whose specialties include pediatrics, family medicine, OB/GYN, cardiology, and behavioral health. Network provider attendance is poor. In 2016 WellCare had eight network providers represented on the UMAC and nine for 2017. CCME reviewed the four meeting minutes WellCare provided (August 2016 – June 2017). For the August 2016 meeting, four network providers attended the meeting and for November 2016, three. For the February 2017 and June 2017 meetings, three network providers attended.

WellCare defines a quorum for the UMAC as at least three voting members, two external physicians and the Medical Director. In the event of a tie vote, the chairperson is the tie-breaker. However, the Medical Director serves as the chairperson for this committee and is also listed as a voting member.

At least annually the QI Department supports a formal evaluation of the effectiveness of the program. WellCare offered CCME the 2016 Medicaid QI Program Evaluation.

Performance Measure Validation

CCME conducted a Validation Review of the HEDIS performance measures following CMS-developed protocols. This process assesses the application of these measures by the health plan to confirm reported information is valid.

WellCare uses Quality Spectrum Insight (QSI) by Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements. The comparison from the previous year to the

current year revealed a strong increase in follow up after hospitalization for mental illness for both the 30-day and 7-day rates. The measures that decreased substantially are Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) and Statin Therapy for Patients with Cardiovascular Disease (spc), Statin Adherence at 80%. WellCare should evaluate changes in rates that are not going in the intended direction, and develop and document specific QI plans to increase or decrease rates as intended. All relevant HEDIS performance measures are detailed in *Table 6*: HEDIS *Performance Measure Data*.

Table 6: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	71.92%	78.83%	6.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.26%	72.45%	18.19%
Counseling for Nutrition	45.50%	55.32%	9.82%
Counseling for Physical Activity	40.39%	43.98%	3.59%
Childhood Immunization Status (cis)			
DTaP	57.65%	71.53%	13.88%
IPV	74.23%	87.04%	12.81%
MMR	78.32%	88.89%	10.57%
HiB	68.11%	82.41%	14.30%
Hepatitis B	73.98%	86.34%	12.36%
VZV	77.81%	88.66%	10.85%
Pneumococcal Conjugate	58.42%	74.77%	16.35%
Hepatitis A	73.47%	84.26%	10.79%
Rotavirus	54.59%	68.52%	13.93%
Influenza	28.32%	31.48%	3.16%
Combination #2	51.79%	67.13%	15.34%
Combination #3	49.74%	64.81%	15.07%
Combination #4	48.47%	62.27%	13.80%
Combination #5	40.82%	53.70%	12.88%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
Combination #6	21.17%	26.62%	5.45%
Combination #7	39.80%	51.62%	11.82%
Combination #8	20.92%	25.93%	5.01%
Combination #9	18.37%	23.38%	5.01%
Combination #10	18.11%	22.69%	4.58%
Immunizations for Adolescents (ima)			
Meningococcal	55.11%	66.67%	11.56%
Tdap/Td	72.82%	82.18%	9.36%
Combination #1	54.36%	66.20%	11.84%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	12.65%	12.27%	-0.38%
Lead Screening in Children (lsc)	59.11%	72.22%	13.11%
Breast Cancer Screening (bcs)	52.97%	53.53%	0.56%
Cervical Cancer Screening (ccs)	61.29%	55.96%	-5.33%
Chlamydia Screening in Women (chl)			
16-20 Years	52.81%	54.60%	1.79%
21-24 Years	62.53%	69.85%	7.32%
Total	55.17%	59.02%	3.85%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	76.41%	78.74%	2.33%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	23.21%	30.28%	7.07%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	54.95%	50.36%	-4.59%
Bronchodilator	75.23%	79.47%	4.24%
Medication Management for People with Asthma (mma)			
5-11 Years - Medication Compliance 50%	49.06%	48.61%	-0.45%
5-11 Years - Medication Compliance 75%	20.63%	20.74%	0.11%
12-18 Years - Medication Compliance 50%	39.41%	43.98%	4.57%
12-18 Years - Medication Compliance 75%	15.27%	12.65%	-2.62%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
19-50 Years - Medication Compliance 50%	53.62%	55.70%	2.08%
19-50 Years - Medication Compliance 75%	21.74%	16.46%	-5.28%
51-64 Years - Medication Compliance 50%	65.22%	46.67%	-18.55%
51-64 Years - Medication Compliance 75%	43.48%	20.00%	-23.48%
Total - Medication Compliance 50%	46.99%	48.20%	1.21%
Total - Medication Compliance 75%	19.84%	17.84%	-2.00%
Asthma Medication Ratio (amr)			
5-11 Years	72.13%	70.34%	-1.79%
12-18 Years	65.13%	58.29%	-6.84%
19-50 Years	37.00%	42.06%	5.06%
51-64 Years	60.00%	52.38%	-7.62%
Total	64.58%	61.82%	-2.76%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	38.93%	39.02%	0.09%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.92%	76.92%	0.00%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	70.07%	69.92%	-0.15%
Statin Adherence 80% - 21-75 years (Male)	50.49%	37.21%	-13.28%
Received Statin Therapy - 40-75 years (Female)	69.44%	72.90%	3.46%
Statin Adherence 80% - 40-75 years (Female)	45.33%	30.77%	-14.56%
Received Statin Therapy - Total	69.80%	71.30%	1.50%
Statin Adherence 80% - Total	48.31%	34.15%	-14.16%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	82.00%	84.84%	2.84%
HbA1c Poor Control (>9.0%)	58.15%	48.64%	-9.51%
HbA1c Control (<8.0%)	36.50%	41.40%	4.90%
HbA1c Control (<7.0%)	NA	NA	Not Required

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
Eye Exam (Retinal) Performed	28.71%	39.14%	10.43%
Medical Attention for Nephropathy	88.32%	92.53%	4.21%
Blood Pressure Control (<140/90 mm Hg)	44.53%	43.44%	-1.09%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	54.37%	58.52%	4.15%
Statin Adherence 80%	45.45%	41.76%	-3.69%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	67.31%	71.67%	4.36%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	35.92%	37.27%	1.35%
Effective Continuation Phase Treatment	21.93%	24.91%	2.98%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	50.31%	42.41%	-7.90%
Continuation and Maintenance (C&M) Phase	59.29%	56.36%	-2.93%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	8.09%	49.62%	41.53%
7-Day Follow-Up	6.25%	28.46%	22.21%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: 13-17 Years		6.67%	NA
7-Day Follow-Up: 13-17 Years		6.67%	NA
30-Day Follow-Up: 18+ Years		11.60%	NA
7-Day Follow-Up: 18+ Years		7.84%	NA
30-Day Follow-Up: Total		11.38%	NA
7-Day Follow-Up: Total		7.78%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	71.57%	75.10%	3.53%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	60.00%	69.75%	9.75%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	77.78%	71.43%	-6.35%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	64.29%	63.17%	-1.12%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NA	NA	NA
6-11 Years	21.43%	14.89%	-6.54%
12-17 Years	20.93%	25.32%	4.39%
Total	21.21%	20.77%	-0.44%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.64%	87.82%	-0.82%
Digoxin	60.00%	52.94%	-7.06%
Diuretics	88.93%	89.92%	0.99%
Total	88.59%	88.52%	-0.07%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	3.42%	1.76%	-1.66%
Appropriate Treatment for Children with URI (uri)	87.09%	87.52%	0.43%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	28.72%	27.01%	-1.71%
Use of Imaging Studies for Low Back Pain (lbp)	74.03%	68.13%	-5.90%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	NA	NA
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	1.56%	0.00%	-1.56%
Total	0.97%	0.00%	-0.97%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	75.63%	76.48%	0.85%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
45-64 Years	85.56%	84.92%	-0.64%
65+ Years	100.00%	100.00%	0.00%
Total	78.93%	79.27%	0.34%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	94.78%	95.23%	0.45%
25 Months - 6 Years	84.17%	83.50%	-0.67%
7-11 Years	90.11%	86.43%	-3.68%
12-19 Years	86.35%	83.58%	-2.77%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	29.21%	33.33%	4.12%
Engagement of AOD Treatment: 13-17 Years	19.10%	17.20%	-1.90%
Initiation of AOD Treatment: 18+ Years	36.26%	38.89%	2.63%
Engagement of AOD Treatment: 18+ Years	7.32%	7.94%	0.62%
Initiation of AOD Treatment: Total	35.73%	38.51%	2.78%
Engagement of AOD Treatment: Total	8.20%	8.57%	0.37%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	82.65%	91.73%	9.08%
Postpartum Care	63.27%	66.93%	3.66%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NA	NA	NA
6-11 Years	73.68%	54.84%	-18.84%
12-17 Years	60.00%	39.39%	-20.61%
Total	63.33%	46.27%	-17.06%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	6.38%	0.52%	-5.86%
21-40 Percent	3.06%	3.10%	0.04%
41-60 Percent	5.10%	5.17%	0.07%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
61-80 Percent	14.54%	11.63%	-2.91%
81+ Percent	70.92%	79.59%	8.67%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	5.35%	1.62%	-3.73%
1 Visit	2.68%	1.62%	-1.06%
2 Visits	4.14%	2.31%	-1.83%
3 Visits	3.89%	5.32%	1.43%
4 Visits	13.38%	8.80%	-4.58%
5 Visits	18.98%	20.83%	1.85%
6+ Visits	51.58%	59.49%	7.91%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	57.14%	58.96%	1.82%
Adolescent Well-Care Visits (awc)	33.82%	41.67%	7.85%

NB: Not a benefit; NR: Not reported; NA: Data not available

Performance Improvement Project Validation

CCME validated PIPs in accordance with CMS protocol titled, *"EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012."* The protocol validates components of the project and its documentation to provide an assessment of the overall study design and project methodology. The assessed components include the following:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

CCME validated two projects using the CMS Protocol for Validation of Performance Improvement Projects. They included Access to Care and Improving Hemoglobin A1C Testing. Table 7, *Performance Improvement Project Validation Score*s provides and overview of each project's validation score.

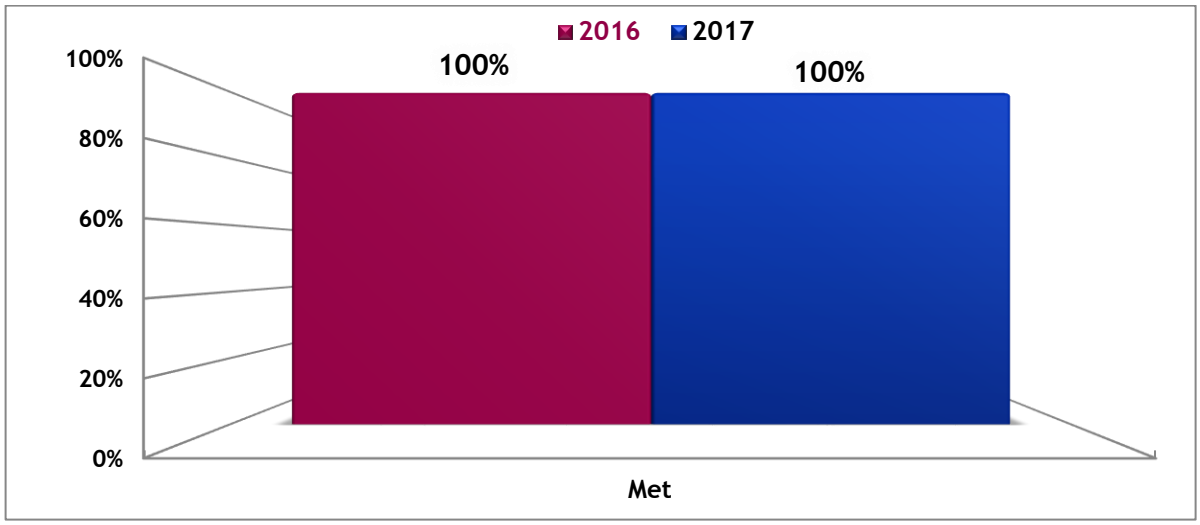
Table 7: Performance Improvement Project Validation Scores

PROJECT	2016 VALIDATION SCORE	2017 VALIDATION SCORE
Access to Care (Non-Clinical)	Not validated	78/78=100% High Confidence in Reported Results
Improving Hemoglobin A1C Testing (Clinical)	94% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results

Both projects scored within the High Confidence Range. There was one recommendation made last year regarding the Improving Hemoglobin A1C Testing PIP, which was to include the personnel and their qualifications in the report. This recommendation was carried out and those elements were included in this year's report for that PIP. Details of the validation of the performance measures and PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 6, Quality Improvement Findings, indicate that all the standards received a "Met" score.

Figure 6: Quality Improvement Findings



Strengths

- All PIPs received validation scores within the High Confidence Range.

Weaknesses

- Monitoring of provider compliance with the health plan's clinical practice guidelines is not included in the QI Program Description or in the work plan.
- WellCare defines a quorum for the UMAC as at least three voting members, two external physicians and the Medical Director. In the event of a tie vote, the chairperson is the tie-breaker. However, the Medical Director serves as the chairperson for this committee and is also listed as a voting member.

Recommendation

- Include the monitoring of provider compliance with the health plan's clinical practice guidelines in the QI Program Description and in the work plan.
- Change the quorum requirements for the UMAC so the chairperson/Medical Director is not considered the tie breaker or a voting member.
- Evaluate changes in rates that are not going in the intended direction, and develop and document specific QI plans to increase or decrease rates as intended.

E. Utilization Management

WellCare's 2017 Utilization Management (UM) Program Description is specific to the SC Medicaid Managed Care product and provides an overview of the structure and operations of the UM Department, including the program's purpose, goals, scope, and lines of authority within the department.

Departmental policies provide more detailed information on the program's functions, requirements, and processes; however, CCME noted issues in policy documentation regarding UM authorization determination timeliness and extension requirements, the form number for the Sterilization Consent Form, references to incorrect section numbers in the SCDHHS Contract and/or SCDHHS Policy and Procedure Manual, and incomplete information regarding emergency and post-stabilization services.

Members and providers can obtain information on UM processes and requirements in various ways, including the Member Handbook, Provider Manual, and WellCare's website. The Provider Manual and WellCare website include an incorrect form/form number for the Sterilization Consent Form. The Provider Manual incorrectly defines the timeframe to file an appeal and incompletely defines expedited appeal resolution and notification timeframes.

UM approval and denial files confirmed timely determinations, requests for additional clinical information when needed, and use of appropriate criteria. However, three Notice of Adverse Benefit Determination letters did not reference the InterQual criteria set used for the initial review. Of these, one stated the criteria used for the review was "medical literature" but did not include the citations of the medical literature reviewed, while two letters did specify the medical literature reviewed.

WellCare developed a program to comply with the requirements of the *SCDHHS Contract, Section 8.5.2.8*. The 2017 Preferred Provider Program Description defines WellCare's "Gold Card" Program, under which providers who have been identified by quality and cost metrics are relieved from authorization requirements for procedures performed in office and in outpatient settings. At the time of the onsite visit, no providers were identified for participation in the program.

WellCare's policies guide staff in the handling and processing of appeals. Issues noted in these policies include out-of-date terminology ("action" instead of "adverse benefit determination"), an incomplete definition of an adverse benefit determination, incorrect timeframes to file an appeal, and incomplete definition of appeal resolution timeframes. In addition, Policy SC22-RX-012, Pharmacy Appeals, is not specific to SC Requirements—the Policy uses verbiage such as, "within the required timeframe specified by each State," and although there is a table at the end of the Policy to define SC requirements, the information in the table is incomplete. Review of appeal files, however, confirms appropriate processes and timeframes are followed.

Case Management (CM) and Care Transitions processes are documented in the Care Management Program Description and in policies. Of note, the Care Management Program Description gives brief information on risk stratification but does not define the CM services provided to members for each of the defined acuity levels. Additionally, CCME could not find this information in CM policies. The Care Management Program Description and CM policies regarding referrals for targeted case management do not include the full scope of diagnoses for which targeted case management referrals are indicated.

WellCare conducts ongoing monitoring and evaluation of the UM Program and develops a formal, written evaluation annually. The UM evaluation is presented to the UMAC and the QIC to assess the objectives, scope, implementation, organization, and effectiveness of the UM Program, and serves as the basis for the following year's Work Plan. The UM Work Plan includes UM initiatives with objectives along with clinical care and service indicators, benchmarks, performance goals, and results from the previous year.

As illustrated in Figure 7, 87% of the standards in the UM section received scores of "Met." All standards scored as "Partially Met" are discussed in detail in the Weaknesses section of this report.

Figure 7: Utilization Management Findings

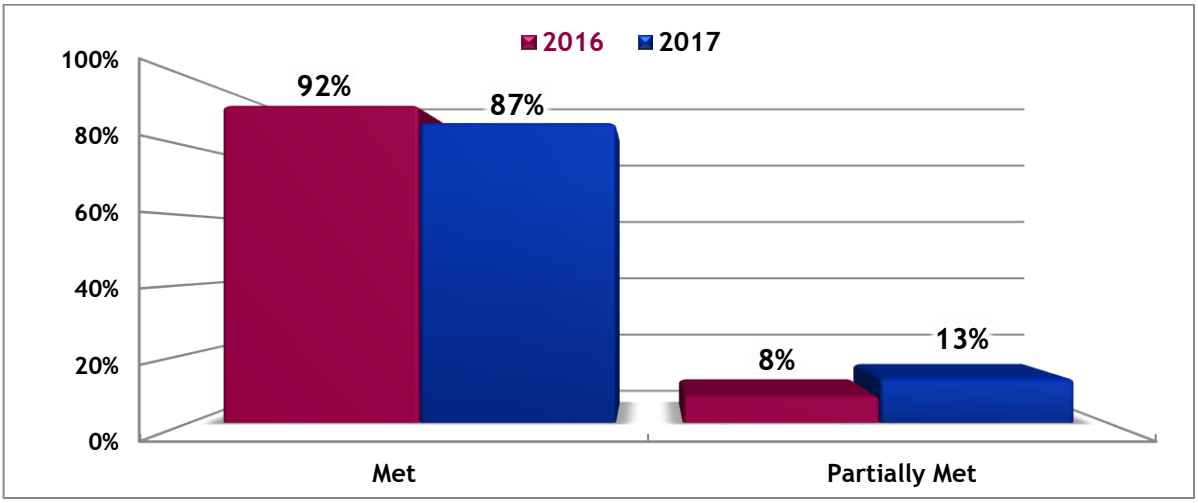


Table 8: Utilization Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
	the mechanism to provide for a preferred provider program	Partially Met	Met
Medical Necessity Determinations	If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Partially Met	Met
	Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Partially Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	Met	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Prior authorization nurses check various databases, including SAM, OIG LEIE, and SC Excluded Providers List, prior to approving out-of-network care.
- Denial files show that providers are informed of the opportunity to have peer-to-peer discussions prior to finalizing the initial denial.

Weaknesses

- CCME noted the following issues in Policy SC22 HS-UM-025, Service Authorization Decisions Policy:
  - Page 3 does not explain that the member's authorized representative can request an extension of the standard determination timeframe.
  - Page 6 does not include that the provider or authorized representative can request an extension of the standard determination timeframe.
  - Page 3 references a three-business day timeframe for expedited authorization determination. All other documentation correctly states the expedited determination timeframe of 72 hours (or three calendar days).
- As specified in the *SCDHHS MCO Policy & Procedure Guide, Section 4.2.27*, the correct form number for the Sterilization Consent Form is SCDHHS Form HHS-687. CCME noted the following issues:
  - Page 2 of Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions, item B (2) (g), lists the Sterilization Consent Form as SCDHHS Form 1723.
  - Page 64 of the Provider Manual lists "OHHS 1723" as the Sterilization Consent Form number.

  - The Sterilization Consent Form available on WellCare's website is the SCDHHS Form 1723.

- CCME noted the following additional issues in Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions:
  - Page 1 incorrectly references the *SCDHHS Contract, Section 4.2.28.* The correct reference is *Section 4.2.27.*
  - Page 2 contains two incorrect references to the *SCDHHS MCO Policy and Procedure Guide, Section 4.1.1.* The correct reference is *Section 4.2.1.*
  - Page 2, item C (1), states, "WellCare shall perform abortions..."
  - Page 3, item C (1) (a) (i) contains an empty table.
- Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services, describes requirements and processes for coverage of emergency and post-stabilization services. The Policy does not include the following requirements:
  - That WellCare will "not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." Refer to the *SCDHHS Contract, Section 4.2.11.1.8* and *Federal Regulation § 438.114 (c) (ii) (A).*
  - That WellCare will "Limit charges to members for any post-stabilization care services to an amount no greater than what the charges would be if the member had obtained the services through an in-network provider. Refer to the *SCDHHS Contract, Section 4.2.11.2.6.*
- Several Notice of Adverse Benefit Determination letters in denial files did not specify the InterQual criteria set used in the review. Of these files, one letter stated the criteria used for the review was "medical literature" but did not cite the specific medical literature used. Two additional letters did cite the articles reviewed.
- Page 1 of Policy SC22-OP-CS-024, Medicaid Customer Service Intake of Member Appeals states, "The Company's Customer Service Department will strictly adhere to the "Appeals Workflow" requirements outlined in this policy and ensure members' issues are resolved in a timely manner." However, no appeals workflow documentation could be found in this Policy. The Policy contains only definitions of appeals-related terms.
- Policy SC22-OP-CS-024, Medicaid Customer Service Intake of Member Appeals, uses the term "action" but should use the term "adverse benefit determination," and is missing part of the definition of an adverse benefit determination.
- Onsite discussion confirmed the timeframe to file an appeal is 60 calendar days from the date printed on the Notice of Adverse Benefit Determination letter. However, the

following items define the timeframe to file an appeal as 60 calendar days from receipt of the Notice of Adverse Benefit Determination:

  - Pages 5, 6, and 12 of Policy SC22 HS-AP-002, Member Appeals Policy
  - Page 93 of the Provider Manual
  - The Initial Adverse Benefit Determination letter (medical necessity) (state-approved on 7/5/17)

- Policy SC22-RX-012, Pharmacy Appeals, is not specific to SC requirements. Issues include:
  - Page 8 states the appeal request must be filed within the requested timeframe per State, from the date of the Notice of Adverse Benefit Determination (i.e., the date printed or written on the notice).
  - Page 20 states the timeframe to file an appeal is 60 days but does not indicate when the 60-day period begins.
  - The Policy does not address the requirement of aiding members in the appeals process.
  - Page 11 states WellCare sends an Acknowledgment letter to the member and the requestor within the required time frame specified by each State, but does not specify the actual timeframe for acknowledging receipt of the appeal.
  - Page 20 states the standard appeal resolution timeframe is 30 days but does not define when that 30-day timeframe begins (i.e. from the receipt of the appeal request).
  - Page 20, states the expedited appeal resolution and notification timeframe is 72 hours but does not define when that 72-hour timeframe begins (i.e. from the receipt of the appeal request).
  - The Policy does not address the timeframe for written notice to the member of the plan's denial of expedited processing for an appeal.
  - The Policy does not address extensions of standard and expedited appeal resolution timeframes.
- Page 95 of the Provider Manual indicates the expedited appeal resolution and notification timeframe is 72 hours, but does not define when the timeframe begins (i.e. from receipt of the appeal request).
- Onsite discussion confirmed that pharmacy appeals data is reported to the UMAC and QIC; however, this is not documented in Policy SC22-RX-012, Pharmacy Appeals.

- The Care Management Program Description gives brief information on risk stratification but does not define the CM services provided to each of the acuity levels. CCME could not find this information in CM policies.
- The Care Management Program Description addresses referrals for Targeted Case Management services for diagnoses of Serious Emotional Disturbance and Seriously Mentally Ill/Serious and Persistent Mental Illness, but does not address Targeted Case Management referrals for alcohol/substance abuse, children in foster care and in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with head/spinal cord injury or a related disability, children and adults with sickle cell disease, and adults in need of protective services. Onsite discussion indicated these diagnoses are included in a "step-action" (desk procedure) document.

Quality Improvement Plan

- Revise page 3 of Policy SC22 HS-UM-025 to indicate the member's authorized representative can request an extension of the standard determination timeframe; revise page 6 of Policy SC22 HS-UM-025to include that the provider or authorized representative can request an extension of the standard determination timeframe); and revise page 3 of Policy SC22 HS-UM-025 to correct the timeframe for expedited authorization determinations.
- Revise Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services, to include the requirements specified in the *SCDHHS Contract, Sections 4.2.11.1.8* and *4.2.11.2.6*.
- Ensure that the criteria used to formulate a denial determination are included in the Notice of Adverse Benefit Determination letters.
- Revise Policy SC22-OP-CS-024 to use the term "adverse benefit determination" instead of "action" and to include the complete definition of an adverse benefit determination. Refer to the *SCDHHS Contract, Section 9.1 (b) (vii)* and *Section 9.1 (b)*.
- Correct the timeframe to file an appeal in Policy SC22 HS-AP-002, Member Appeals Policy, the Provider Manual, and the Initial Adverse Benefit Determination letter (medical necessity) (state-approved on 7/5/17).
- Revise Policy SC22-RX-012, Pharmacy Appeals, to include or correct the following information, or retire this Policy and include information on pharmacy appeals in Policy SC22 HA-AP-002.
  - The SC-specific timeframe to file appeals, including when the timeframe begins
  - The requirement of aiding members in the appeals process
  - The timeframe for acknowledging receipt of an appeal

- Information on when the standard appeal resolution timeframe begins
- Information on when the expedited appeal resolution timeframe begins
- The timeframe for written notice to the member of the plan's denial of expedited processing for an appeal
- Information on extensions of standard and expedited appeal resolution timeframes

- Revise page 95 of the Provider Manual to clearly define the expedited appeal resolution and notification timeframe as 72 hours from receipt of the appeal request.

Recommendations

- Update the Sterilization Consent Form number in Policy SC22-HS-UM-030 and the Provider Manual.
- Update the WellCare website to provide the correct Sterilization Consent form.
- Update the incorrect references to the *SCDHHS Contract* and the *SCDHHS MCO Policy and Procedure Guide* in Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions.
- In page 2 of Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions, correct the statement that WellCare performs abortions and update or remove the empty table on page three.
- Revise Policy SC22-OP-CS-024 to include the referenced appeals workflow or remove the reference to the workflow.
- Update Policy SC22-RX-012, Pharmacy Appeals, to indicate pharmacy appeals data is reported to the UMAC and QIC.
- Define the CM services provided to each of the acuity levels (low-, moderate-, and high-risk) in either the Care Management Program Description or in a CM Policy.
- Revise the Care Management Program Description to include the full list of diagnoses for which Targeted Case Management referrals are made

F. Delegation

WellCare executes written agreements with all entities performing delegated services. Many of the delegations are corporate contracts that support WellCare. Addendums define any state specific contract requirements.

WellCare's delegated services are defined in Table 9, Delegated Entities and Services.

Table 9: Delegated Entities and Services

Service	Delegated Entities
UM	Advanced Medical Review; CareCore National, LLC d/b/a EviCore Healthcare; Health Help, LLC; Progeny Health, Inc.
UM	Behavioral Health - Focus Health
Nurse Advice Line	CareNet
Pharmacy	CVS
Customer Service	Teleperformance; The Results Companies; SPH Analytics
Crisis Line	Health Integrated, Inc.
Case Management	Alere
Vision	March Vision
Credentialing	AU Medical Center (MGC Health, Inc.); Greenville Hospital System; Integra Partners, IPA; Linkia, LLC; Mary Black HealthNetwork Inc.; Medical University Hospital Authority; Minute Clinic; Preferred Care of Aiken, Inc.; Regional Health Plus LLC; Roper St. Francis Healthcare (CareAlliance Health Services); St. Francis Physician Services; Take Care Clinics; United Physicians, Inc. (formerly Provider Healthlink of South Carolina, LLC)

The Delegation Oversight Committee coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory and accreditation requirements. The committee includes corporate and plan representation and the Director of Health Services Delegation Oversight, chairs the committee. The Director of Quality Improvement from SC, is a member of the committee. This committee reports to the QIC.

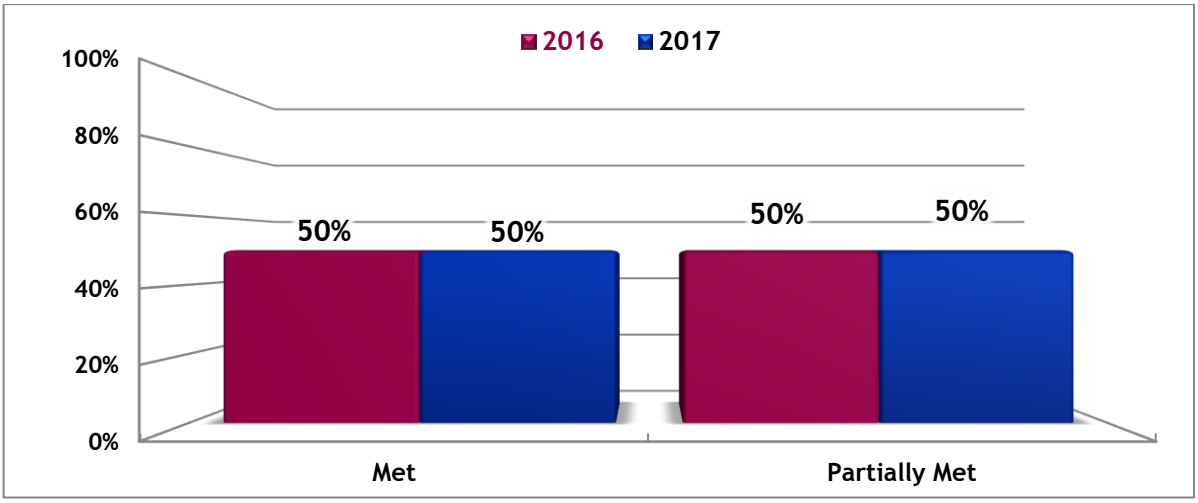
Policy SC22 CP-AO-007 SC – Delegation Oversight, and Procedure SC22-CP-AO-007-PR-001 define the process for evaluation and oversight of delegated entities to ensure compliance of the delegated functions. Both the policy and procedure incorrectly reference Procedure SC22 HS-CR-001-PR-001 which was retired and merged with Policy SC22 HS-CR-001.

WellCare has a detailed process of oversight for delegated entities which includes annual oversight, and monthly and/or quarterly data review with corrective action as appropriate. WellCare uses scorecards that are tailored to each market/line of business and address federal, state and accreditation requirements.

CCME received proof of oversight activities for all delegated entities. Issues were identified such as inconsistent or incomplete information; out-of-state providers (i.e. Georgia) that see SC members do not appear to be credentialed/ recredentialed to SC requirements; Ownership Disclosure forms and CLIA certificates do not appear to always be collected as required. Specifics are discussed in the "Weaknesses" section. During onsite discussion WellCare indicated additional training may be needed for employees that conduct delegation oversight reviews.

Figure 8 shows that one standard in Delegation received a "Met" score and the other standard received a "Partially Met" score.

Figure 8: Delegation Findings



Weaknesses

- Policy SC22 CP-AO-007 SC – Delegation Oversight, and Procedure SC22-CP-AO-007-PR-001 incorrectly reference Procedure SC22 HS-CR-001-PR-001 which was retired and merged with Policy SC22 HS-CR-001.
- CCME identified these issues while reviewing entity oversight materials:
  - Greenville Health System- The credentialing file review tool showed "Y" that Ownership Disclosure forms (ODF) were present in all the files, but "N" they were not compliant. The recredentialing file review tool showed the ODF's were "N" not present but "Y" were compliant. This information is inconsistent. It does not appear that Greenville Health System collects ODFs for recredentialing.
  - AU Medical Center (MGC Health, Inc.) – These are Georgia providers that see SC patients. The credentialing and recredentialing file review tools showed "N/A" for ODFs and CLIAs. The global credentialing tool stated N/A for SC requirements with the statement, "N/A providers are credentialed in Georgia and can see South

Carolina patients Attachments Required Comments. Required N/A providers are credentialed in Georgia and can see South Carolina patients." WellCare needs to ensure that SC credentialing requirements are followed for all providers that see SC members.

- Mary Black Health Networks, Inc. – The global review tool indicated there was no policy for review of Ownership Disclosure form 1514 upon initial credentialing, re-credentialing or ownership changes. The comment made by the reviewer was, "compliant – this is sufficient since it is a new requirement and will be verified post implementation." All credentialing and recredentialing files reviewed showed N/A for ownership disclosure and for the CLIA. The complete date for this review was 12/6/16 and this was not a new requirement. In addition, the "Document Present" column of the credentialing and recredentialing file review tools were left blank.
- Minute Clinic – The global review tool indicated they do not obtain CLIA certificates for their individual providers because the certificate is obtained at the practice level. However, for all providers that are performing laboratory services a copy of the CLIA must be in the file. This includes if the provider works for a practice. A copy of the practice CLIA needs to be in the file.
- Take Care Clinics – The global review tool indicated "No" in #1-135 for the delegated entity doing business in SC and shows N/A for all the SC requirements. The file review tool showed GA providers reviewed with N/A for SC requirements. However, the Annual Audit Results letter showed that SC Medicaid was included in the review.
- St. Francis Physician Services - The global review tool #161-162 shows the entity attached the Ownership Disclosure form; however, the auditor indicated N/A and stated, "Entity not currently delegated for Medicaid; Individual Practice ODF's submitted with credentialing files; N/A". However, the Oversight Results letter stated a pre-delegation audit for the SC Medicaid lines of business was conducted.

Quality Improvement Plan

- Update Policy SC22 CP-AO-007 and Procedure SC22-CP-AO-007-PR-001 to remove the incorrect references to Procedure SC22 HS-CR-001-PR-001.
- Address issues identified in the oversight documents such as inconsistent or incomplete information; ensure out-of-state providers (i.e. Georgia) that see SC members are credentialed/recredentialed to SC requirements; ensure Ownership Disclosure forms and CLIA certificates are collected as required.

Recommendations

- Consider implementing an internal spot-check process for WellCare employees conducting delegation oversight reviews to identify training issues in the delegation oversight process.

G. State Mandated Services

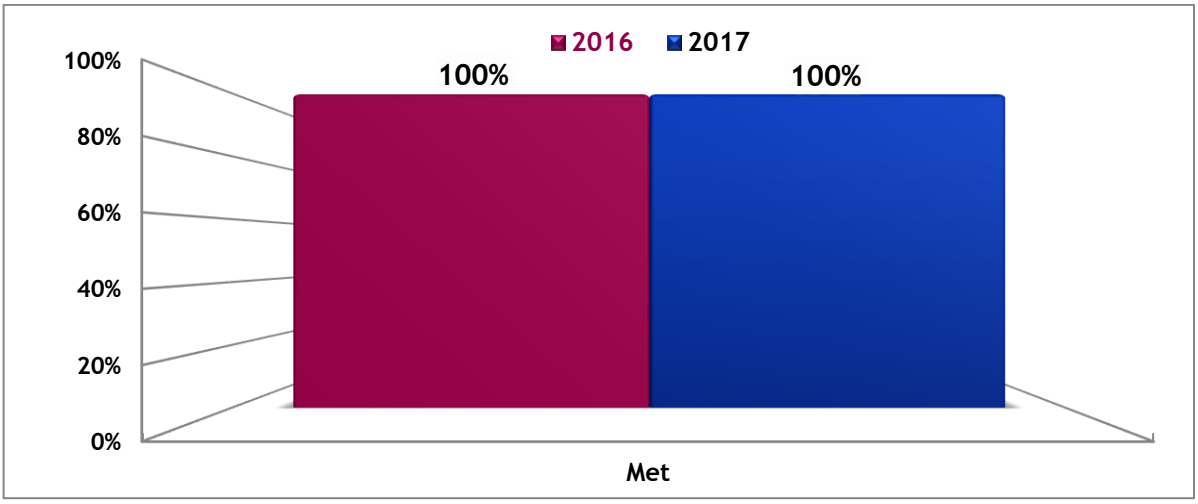
WellCare provides all core benefits required by the SCDHHS Contract.

WellCare informs providers about the EPSDT program through the Provider Manual, during provider relations orientation, and annually. Providers receive monthly membership lists of members who have not had an encounter within 120 days of enrollment and members who are not following the recommended services under the EPSDT Program. Providers are to monitor, track, and follow up with members who have not had a health assessment screening and those who miss appointments.

WellCare assesses providers' compliance with member monitoring, tracking, and follow-up through random QI Department Medical Record Review (MRR) audits. The plan gives providers written notification of the audit results, contact information for clarification if needed, and access to a Quality Practice Manager. WellCare automatically selects providers who do not successfully pass the MRR for another MRR during the subsequent review cycle.

As noted in Figure 9, State Mandated Services, WellCare received a score of "Met" for 100% of the standards in the State Mandated Services section for the 2017 EQR as well as the 2016 EQR.

Figure 9: State Mandated Services



ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

October 23, 2017

Kathy Warner
Chief Operating Officer
WellCare of South Carolina
200 Center Point, Suite 180
Columbia, SC 29210

Dear Ms. Warner:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2017 External Quality Review (EQR) of WellCare of SC is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **December 19th and 20th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **November 6, 2017.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.
Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review
Enclosure
cc: SCDHHS

External Quality Review 2017

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2016, and 2017.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from April 2016 through September 2017. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of September 2016 through September 2017.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of October 2016 through October 2017. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of October 2016 through October 2017, including any medical information and approval criteria used in the decision. Please

include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at** https://eqro.thecarolinascenter.org
- **should be submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2017

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Documentation related to the Preferred Provider Program.
3. Documentation of WellCare's annual review of members in the Pharmacy Lock-in Program.
4. Copies of the most current Initial Adverse Benefit Determination Letters (medical necessity and administrative).
5. Copies of minutes from at least two of the most recent Appeals Committee meetings.
6. Copy of the WellCare Provider Orientation PowerPoint mentioned in the Provider In-Service Checklist.
7. Copy of WellCare's Cultural Competency Plan mentioned in policy SC22 SM-005.
8. Any policy or other documentation addressing targeted case management referrals and coordination.
9. Several credentialing and/or recredentialing files were missing information or need explanation. See attached list.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM VALIDATION WORKSHEET

Plan Name:	WellCare
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2016
Review Performed:	12/2017

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	This was verified by in-house and meets all review requirements.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	NA	NA
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	WELLCARE
Name of PIP:	IMPROVING ACCESS TO CARE – NONCLINICAL
Reporting Year:	2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected through data collection, and noted on page 2.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is documented on page 4 of the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined on page 5.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure is focused on processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Relevant populations are included.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire population captures all relevant enrollees.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed on page 7.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection uses programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions are directly related to barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted for baseline year 2016.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are clearly presented.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Only baseline results are presented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Only baseline results are presented.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Improvement cannot be evaluated with only baseline results.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement cannot be evaluated with only baseline results.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Improvement cannot be evaluated with only baseline results.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement cannot be evaluated with only baseline results.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	1
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	78
Project Possible Score	78
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**WELLCARE**
Name of PIP:	IMPROVING HEMOGLOBIN A1C TESTING - Clinical
Reporting Year:	2015-2016
Review Performed:	2017

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Analysis of data regarding enrollee care.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This addresses a key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question was stated in on page 3 of the document.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	A clear definition of enrollees to whom the study question is relevant is documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data collection approach captured all enrollees to whom the study measure applied.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
protected against bias? **(10)** *Specify the type of sampling or census used:*		
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected was documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source was identified as Administrative Data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	There was a systemic method for collecting claims/encounter files of all eligible members using programmed pulled data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	There was consistent data collection using program pulled data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The data analysis plan was specified as once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel involved with study was provided in Attachment A.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Several interventions were implemented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis of findings was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The analysis identified the baseline and one repeat measurement.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis included interpretation of success and continued action plans.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Measurement was repeated once.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement from baseline was documented.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be	**MET**	Improvement has face validity.

Component / Standard (Total Points)	Score	Comments
the result of the planned quality improvement intervention)? **(5)**		
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance at .05 level was demonstrated via Fisher's exact test.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Measurement has only one re-measurement period. We cannot judge sustainment.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	**NA**	**NA**
TOTAL		

Project Score	**91**
Project Possible Score	**91**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**WELLCARE**
Survey Validated	**CAHPS ADULT**
Validation Period	2017
Review Performed	12/2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

	Survey Element	Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to National Committee for Quality Assurance (NCQA). WellCare had a sample size of 1 654. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 17.7%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* *Recommendation: Implement strategies to increase response rates such as oversampling and adding reminders to call center script.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* *CAHPS Analysis SC CAID 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 17.7%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Customer Service, coordination of care, getting care quickly, and ease of filling out forms all had an increase in score and scored at the 50th percentile and higher. Rating of personal doctor and how well doctors communicate all scored at the goal rate of the 25th percentile. All other composites scored below the 25th percentile which was below average. Documentation *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

	Results Elements	Validation Comments And Conclusions
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

CCME EQR Survey Validation Worksheet

Plan Name	**WELLCARE**
Survey Validated	**CAHPS CHILD**
Validation Period	2017
Review Performed	12/2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. WellCare had a sample size of 2,200. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 13.0%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD* *Recommendation: Implement strategies to increase response rates such as oversampling and adding reminders to call center script.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD* *CAHPS Analysis SC CAID 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 13.0%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The 2017 survey results showed 2 measures in the 90th percentile, 4 measures in the 75th percentile, 3 measures in the 50th percentile, and 3 measures at the 25th percentile or below. Four measures did not have enough respondents to make it a valid sample. The child survey did very well in the health plan domain, with 2 measures – getting needed care and customer service rated at the 75th percentile, one measure rated at the 90th percentile- ease of filling out forms, and one measure rated below the 25th percentile – Rating of health plan. This measure did not meet goal for the 2nd year in a row based on meeting at least the 50th SPH Analytics BOB or Quality Compass Mean threshold. Documentation*: SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – CHILD; CAHPS Analysis SC CAID 2017*

	Results Elements	Validation Comments And Conclusions
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2017 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**WellCare of SC**
Collection Date:	2017

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					WellCare's policies and procedures are in one document with the policy listed first, followed by the corresponding procedure. The master list of policies and procedures is well organized and shows effective dates, review dates, revision dates, and the scheduled review date. Reviews are completed annually. The annual review process is electronic in Compliance 360 with a point person managing the process. The staff is notified of any changes to policies via email.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Kathy Warner, WellCare's Plan President, leads the leadership team and provides day-to-day oversight of business activities.
1.2 Chief Financial Officer (CFO);	X					The Vice President, Regional Financial Officer is Jeff Skobel. The Senior Director of Finance is noted as an open position. According to staff, this position was recently filled.
1.3 * Contract Account Manager;	X					The Director of State Regulatory Affairs is noted as a vacant position on the organizational chart. However, this position was recently filled by Mark Ruise.
1.4 Information Systems personnel;						IT functions are managed out of the corporate offices in Tampa, Florida. Nicholas Barfield is the Regional System Support Specialist who supports IT functions locally.
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims/ Encounter Processing Staff,	X					Most of the claims processing is conducted in the corporate office in Tampa, Florida. Staff are available in SC for some claims processing and problem resolution related to claims.
1.5 Utilization Management (Coordinator, Manager, Director);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.1 Pharmacy Director,	X					Nancy Youssef is a SC licensed pharmacist and serves as the Director State Pharmacy.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Mark DaShiel is the Director of Quality Improvement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Provider Services is divided into two areas: Provider Operations and Provider Relations. Provider Operations, under the directions of Christy Lassiter, Sr. Director Strategic Operations is responsible for contracting, credentialing and recredentialing of network providers. Julia Pinckney, Sr. Director Network Management in the Provider Relations area is responsible for provider education, recruitment, contracting, new provider orientation, and monitoring of quality and regulatory standards.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Anton Brown serves as director of community relations/member services manager.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					WellCare's Senior Medical Director is Dr. Robert London. Dr. London is board certified in OB/GYN, licensed in SC and oversees the clinical functions of the organization.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 *Compliance Officer;	X					Mark Ruise is listed as the Market Compliance Officer on the organizational chart. However, Mr. Ruise has moved into the position of Director of Regulatory Affairs and Lori Don Gregory is now the Interim Compliance Director.
1.10.1 Program Integrity Coordinator,	X					
1.10.2 Compliance /Program Integrity Staff,	X					
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist;	X					Dr. Sultan Simms is a board certified, SC licensed psychiatrist for WellCare.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					The included ISCA documentation states that claims are monitored for timeliness and accuracy. WellCare meets the organization's internal requirements and surpasses the MCO contract requirements by completing 99.72% of claims in 30 days and 99% within 90 days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					The MCO provided comprehensive materials detailing their procedures which follow HIPAA standards and practices. The documentation states that WellCare accepts and generates HIPAA-compliant electronic transactions.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Documentation provided indicates that the IT solutions for the MCO's plan have the capability to track demographics and enrollment data across multiple internal systems. According to the documentation provided, an audit performed by an independent agency verified this information.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					WellCare's documentation demonstrates that it can provide the required reports and meet its contractual obligations. The provider's documentation includes such items as employee training data, quality control measures, data flow diagrams, infrastructure details, and the performance data that all show that claims can be processed in a satisfactory manner.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					WellCare has provided extensive documentation detailing their data security standards, policies and procedures. Their cataloged information's contents meet all the prescribed requirements including: •Handling and labeling data •Monitoring of IT resources •Passwords •Acceptable use of devices •Secure storage requirements •Email, instant messaging and social media •Safeguarding WellCare property •Protection from damage or theft •Facility security •Prohibited activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					WellCare provided documentation regarding system and information security as well as access management. According to their reported policies and procedures, the MCO meets the standards required. They have documented safe computing practices which are required to protect the systems and data used to fulfill the MCO contract.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					WellCare provided documentation detailing an extensive and thorough Disaster Recovery/Business Continuity plan. Testing of the plan was performed from February 27, 2017 to March 2, 2017, which was successful except for "no significant findings and one minor procedural audit." The test was based on the scenario of experiencing a Category 5 hurricane. With recent DR improvements, the results demonstrate WellCare's Disaster Recovery plan exceeds the SCDHHS MCO Contract requirements. WellCare's Internal Audit Team indicated their intention to continue to refine and advance the DR process.
I D. Compliance/Program Integrity						
1. The MCO has written policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					The WellCare Corporate Compliance Program is in place, and includes appropriate training for the Plan President, directors, providers, employees, and external vendors. Fraud, waste, and abuse hotline phone numbers are documented in the Provider Manual, Member Handbook, and the WellCare website. Fraud, waste, and abuse hotline phone numbers are also included in employee information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Written policies, training plans, and/or the Compliance Plan includes employee and subcontractor training.	X					
3. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Market Compliance Committee is the local committee established to provide local oversight of the Compliance Program in SC. This committee meets on a quarterly basis. Good attendance and quorums were documented in the minutes of each committee meeting.
4. The MCO has policies and procedures in place that define the processes used to conduct post payment audits and recovery activities for fraud, waste, and abuse activities.	X					WellCare's process for conducting claims audits is discussed in Policy SC22 OP-CL-037, South Carolina – Claims Audit Policy.
5. The MCO has policies and procedures that define how investigations of all reported incidents are conducted.	X					
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Procedure C13HIP.01.004-PR-001, HIPAA Handbook Procedure is a guide addressing controls that relate to the handling of protected health information. Section 1.15, HIPAA Training outlines the required trainings.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Credentialing and recredentialing is addressed in the corporate Credentialing Program Description and Policy SC22 HS-CR-001, South Carolina – Credentialing and Re-credentialing. Additional policies address various processes or guidelines related to the Credentialing Department. CCME identified these issues: •The Exclusion and Termination for Cause List is not mentioned in <u>any</u> of the credentialing policies or documents. It is listed as a requirement in the *SCDHHS Policy and Procedure Guide, Sections 11.1.21 and 11.2*. Onsite discussion confirmed that WellCare reviews the list in their processes; however, it was not considered a credentialing function. •Many of the policies still reference retired Procedure SC22 HS-CR-001-PR-001 which was merged into Policy SC22-HS-CR-001. Examples include the following: •Page 32 of SC22-HS-CR-001 •Page 1 of SC22-HS-CR-004 •Page 2 of SC22-HS-CR-010 •Pages 1 and 2 of SC22-HS-CR-0162 •Page 6 of SC22-CP-AO-007 • Page 9 of SC22-CP-AO-007-PR-001 •Page 10 of Policy SC22-CP-AO-007-PR-001 references retired Procedure SC22 HS-CR-046-PR-001 which was merged into Policy SC22-HS-CR-046. *Quality Improvement Plan: Address WellCare's process for ensuring the Exclusion and Termination*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for Cause List is reviewed at initial credentialing, recredentialing, and monthly in appropriate policies and documents. Update identified policies to remove the incorrect references to retired procedures.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					Policy SC22-HS-CR-019, Credentialing Committee-Peer Review, defines the peer-review process of designating a local CC that includes representation of participating practitioners to evaluate, approve, or deny the credentials of new and recredentialing applicants. The CC meets monthly and is chaired by Dr. Robert London, Sr. Medical Director. Other voting members of the committee include four network physicians with the specialties of cardiology, hematology/oncology, family medicine and pediatrics; and a licensed clinical social worker representing behavioral health. The 2017 Credentialing Committee Members-Internal and External list incorrectly shows Mark DaShiell as a voting member of the committee. Onsite discussion confirmed a quorum is met with two voting members plus the committee chair. Corporate Medical Directors review and approve clean files. The local CC reviews and approves all other files. *Recommendation: Update the 2017 Credentialing Committee Members-Internal and External list to show the correct voting members of the committee.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed below.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;		X				Reviewed credentialing files did not contain evidence that the Exclusion and Termination for Cause List was queried; however, onsite discussion confirmed this list is queried appropriately. All credentialing files reviewed did contain evidence of query of the SC Excluded Providers List. *Quality Improvement Plan: Credentialing files should contain evidence of query of the Exclusion and Termination for Cause List.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;		X				Two credentialing files for licensed professional counselors did not address hospital admitting arrangements. Onside discussion confirmed that WellCare does not pursue hospital admitting arrangements for licensed professional counselors; however, admitting arrangements should be addressed for all providers. *Quality Improvement Plan: Ensure hospital admitting arrangements are addressed for all providers during the credentialing process.*
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed below.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;		X				Recredentialing files reviewed did not contain evidence the Exclusion and Termination for Cause List had been queried; however, onsite discussion confirmed this list is queried at recredentialing. All recredentialing files reviewed did contain evidence of query of the SC excluded providers list. *Quality Improvement Plan: Recredentialing files should contain evidence of query of the Exclusion and Termination for Cause List.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					One recredentialing file had an Ownership Disclosure form signed 9/8/15 when the CC approval was 5/15/17. Onsite discussion confirmed the Plan seeks to obtain updated forms from providers but after three attempts, they do not pursue it. *Recommendation: WellCare should ensure they obtain updated Ownership Disclosure forms as required.*
4.3 Review of practitioner profiling activities.	X					Policy SC22 HS-CR-010, SC – Quality Review defines the procedures for ensuring that a provider's quality-monitoring and quality-review information is incorporated into the credentialing peer-review process. Provider quality of care or conduct issues are forwarded to the Credentialing Peer Review

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee for review and determination if the Medical Director determines it is warranted. On a quarterly basis, the Credentialing Department submits a list of providers due for re-credentialing to the Plan Quality Improvement Analyst (QIA). The QIA checks the database for confirmed quality issues; confirmed trends; grievances; and corrective provider education. If a quality issue is found, a quality profile is provided to Credentialing.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy SC22 HS-CR-020, SC – Hearing and Appellate Review, defines the procedure for when a practitioner does not meet the Plan's quality standards of care, conduct, participation, or service criteria. All confirmed quality of care or conduct issues are referred to the SC CC for peer-review determination. In the event the recommendation of the SC CC imposes corrective action that alters a practitioner's relationship with the Plan up to and including termination, the practitioner is entitled to a second level, appellate review. Policy SC22 HS-QI-015, SC-Quality of Care Issues, defines the guidelines and procedures for identifying, investigating, tracking, trending, and reporting potential and/or actual quality of care issues. Issues are tracked and trended by volume or occurrence and submitted for review and incorporation into the peer-review process.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The credentialing/recredentialing guidelines for organizational providers is addressed in Policy SC22 HS-CR-009, SC - Assessment of Organizational Providers. The Exclusion and Termination for Cause List is not mentioned in the policy as a verification source that is queried. This is a requirement in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SCDHHS Policy and Procedure Guide, Sections 11.1.21 and 11.2. Reviewed organizational files appeared to contain appropriate documentation except for proof of query of the Exclusion and Termination for Cause List. Page 12 of Policy SC22 HS-CR-009 has the following statement that is no longer applicable per onsite discussion, "An initial onsite review is required of all Primary Care Physicians and OB/GYN physicians acting as Primary Care Physicians, prior to the completion of the initial credentialing process." *Quality Improvement Plan: Update Policy SC22 HS-CR-009, SC - Assessment of Organizational Providers to include the Exclusion and Termination for Cause List as a required query and ensure credentialing/ recredentialing files contain proof of query. Remove the statement regarding onsite visits at initial credentialing that is no longer applicable.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				Policy SC22 HS-CR-046, SC Ongoing Monitoring of Providers, defines the procedure for monthly ongoing monitoring of network providers to ensure compliance with all applicable federal and state Medicaid contract requirements. The policy does not address querying the Social Security Death Master File (SSDMF) as required in the *SCDHHS Contract, Section 11.2.11.* In addition, it does not address querying the Exclusion and Termination for Cause List addressed in the *SCDHHS Policy and Procedure Guide, Sections 11.1.21 and 11.2.* Onsite discussion confirmed that WellCare is looking to implement the SSDMF query into the ongoing monitoring process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update Policy SC22 HS-CR-046, SC Ongoing Monitoring of Providers to address queries of the SSDMF and the Exclusion and Termination for Cause list for monthly monitoring.
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy SC22 OP-NI-001, SC - GeoAccess Reporting, outlines the performance standards used for ensuring geographic access to providers for Medicaid members. PCPs are evaluated for each type (family/general practitioners, internal medicine, pediatricians), as well as combined, within 30 miles /45 minutes of a member's home. OBGYNs acting as PCPs are also included. Evidence of GeoAccess reporting for mileage and drive time was received in the desk materials along with other reports that address the gap analysis. Results from 2016 QI Program Evaluation show that 100% of members have access to a PCP within 30 miles.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy SC22 OP-NI-001, SC - GeoAccess Reporting, defines the performance standards as follows: specialty providers (including hospitals) as being measured within 50 miles/75 minutes. GeoAccess reports were received which show measurement of specialists as two providers within 50 miles/75 minutes with the exceptions as follows: hospitals one within 50 miles/75 minutes and pharmacies one within 30 miles/45 minutes. The 2016 QI Program

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Evaluation reflects the following overall availability measurement results: specialist 98.24%, pharmacy 100%, behavioral health 97.01% and hospitals are at 100% compliance.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy SC22 OP-NI-001, SC - GeoAccess Reporting states, "on a biannual basis at a minimum, to ensure geographic access to healthcare services in accordance with the Medicaid contract, the Company will evaluate the geographic sufficiency of the network and take action as appropriate."
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy SC22 SM-005, SC Cultural Competency, addresses that WellCare will have a comprehensive written Cultural Competency Plan (CCP) that describes how the Plan ensures that services and materials are provided in a culturally competent manner to all members, including those with limited English proficiency. The 2016 QI Program Evaluation showed that cultural competency was assessed during the CAHPS survey. Two additional questions were added to the survey relating to whether doctors were meeting the special cultural and/or spoken language needs for adult and child. Analysis showed the health plan was adequately meeting the member's cultural needs. Cultural Competency is addressed in the Provider Manual and it states that registered website provider portal users may access Cultural Competency training.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					The WellCare website searchable Provider Directory is detailed and user friendly. A paper Provider Directory which contains appropriate information was received in the desk materials. Members can contact Member Services for a paper copy of the Provider Directory. Policy SC22 OP-NI-003, SC- Provider Directory Production, defines the minimum information listed in the Provider Directory and it appears to omit "office hours." However, this is addressed in the paper and web versions of the directories. Policy SC22 OP-PC-021, SC Web-Based Provider Directory, addresses information that is loaded to the web-based Provider Directory, which is updated nightly. *Recommendation: Update Policy SC22 OP-NI-003, SC-Provider Directory Production, to include "office hours" in the list of minimum information that is required to be included in the Provider Directory.*
3.Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy SC22 OP-NI-002, SC Provider Appointment and After-Hours Coverage, defines the process of timely member access to care within the provider networks through Appointment Accessibility and After-Hours telephone surveys. The policy defines the standards for twenty-four access and appointment wait times for PCPs and behavioral health providers. The monitoring of service accessibility includes

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducting after-hours survey and appointment availability survey with a 90% or greater compliance threshold for all access standards. A few inconsistencies regarding access standards were identified between documents as follows: •Behavioral health routine care is listed as "less than 10 days" in the Member Handbook and Provider Manual; listed as "<= 10 business days" in the Timely Access Report; and listed as "less than 10 business days" in Policy SC22 OP-NI-002. •Page 24 of the Provider Manual states PCP routine/wellness visits as "within 4 to 6 weeks" when all other documents list it as "within 4 weeks." •The Provider In-Service Checklist states the following incorrect timeframes for availability, "Urgent, 1 day: Routine 1 week: Preventative 1 month." WellCare used The Myers Group, an outside vendor, to complete the accessibility and availability audits in 2017. The audit measured PCPs and specialists (including behavioral health providers) for appointment access. After-hours access was conducted for PCPs and pediatrics with a 77.3% compliance rate. The Appointment Availability & Accessibility Timely Access Report lacked information such as how the audit was conducted (phone calls to providers?), defined goals for the access standards, analysis as to whether the access standard goals were met, interventions to address low results, and outcome of follow-ups for non-compliant providers. *Quality Improvement Plan: Correct the inconsistencies regarding provider access standards in the Member Handbook, Provider Manual, Policy SC22*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						OP-NI-002, and the Provider In-Service Checklist. *Recommendation: Improve analysis of the Appointment Availability & Accessibility Timely Access Report. In addition, assess barriers and implement interventions to address the low results of the PCP and specialty (including behavioral health) accessibility surveys.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the annual EQR process for WellCare, a CCME performed a Telephonic Provider Access Study that focused on primary care providers. WellCare provided a list of current providers to CCME, from which a population of 1,858 unique PCPs was found. CCME selected a random sample of 304 providers from this population for the Telephonic Provider Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. Calls were successfully answered 60% of the time (162 out of 268) when omitting the 36 calls answered by personal or general voicemail messaging services. When compared to last year's results of 42%, this year's study had a statistically significant increase in successful calls ($p<.01$). For those not answered successfully (n=142 calls), 59 (42%) were unsuccessful because the provider was not at that office or phone number listed. Of the 162 successful calls, 132 out of the 156 providers that responded to the question (85%) of the providers indicated that they accept WellCare health plan, although five (3%) indicated that this occurred only under certain conditions. And of the 132 that accept WellCare health plan, 104 (79%) responded that they are accepting new Medicaid patients.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Regarding a screening process for new patients, 42 (41%) of the 102 providers that responded to the item indicated that an application or prescreen was necessary. Of those 42, 13 (31%) indicated that an application must be filled out whereas 8 (19%) require a review of medical records before accepting a new patient, and 13 (31%) required both. When the office was asked about the next available routine appointment, 73 (73%) of the 99 responses met contact requirements.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					WellCare's Provider Services Department is comprised of two teams – Provider Relations and Provider Operations. The Provider Relations team is responsible for provider education, recruitment, contracting, new provider orientation, monitoring of quality and regulatory standards such as Healthcare Effectiveness Data and Information Set (HEDIS®), and investigation of member grievances. The Provider Operations team consists of contract operations and they collect credentialing and re-credentialing documents. Policy SC22 HS-PR-001, SC Provider Training and Education, defines the process of providing new orientation training to providers within 30 calendar days. The initial orientation is performed, in person, at the provider's office, or a mutually agreed site. A provider In-Service Checklist is used for each orientation session and outlines all topics to be covered. The provider signs and dates this list is, along with a list of participants who were present.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Evidence of the initial orientation is stored in Salesforce, along with the in-service checklist signature that is obtained.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing provider training is accomplished through orientations, newsletters, email, faxes, letters, onsite training, or other means. Methods of training include group orientations, seminars, one-on-ones, webinars, phone calls, email, etc. In addition, the provider portal on the website contains training modules.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines and Preventive Health Guidelines defines the process of evaluation and adoption of practice guidelines. Preventive health guidelines are designed to detect and improve the health status of WellCare members by providing preventive care to screen for a host of acute and potentially chronic illnesses. The guidelines are reviewed at least once a year and revised as necessary. The UMAC and QIC review and approve the guidelines.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Practice guideline are distributed to physicians via newsletter, website or Provider Manual. Upon request, WellCare disseminates the guidelines in writing to providers, Medicaid members and potential Medicaid members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines and Preventive Health Guidelines defines the process of evaluation and adoption of practice guidelines. The clinical practice guidelines are based on medical evidence and are relevant to the population served. The guidelines support quality and efficiency of care by establishing guidance to improve care for chronic disease and/or preventive care measures. The guidelines are reviewed at least once a year and revised as necessary. The UMAC and QIC review and approve the guidelines.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					Practice guidelines are distributed to physicians via newsletter, website or the Provider Manual. Upon request, WellCare disseminates the guidelines in writing to providers, Medicaid members and potential Medicaid members.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy SC22 HS-UM-019, SC - Care Coordination Continuity of Care and Transition of Care, ensures that its members' primary health care is directed and coordinated by a PCP in partnership with WellCare's providers in coordinating appropriate medical services for members requiring transition of care services. The policy addresses care coordination, continuity of care, and transition of care for members. PCPs are monitored via HEDIS visits and through over and underutilization review.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy SC22 HS-QI-005, South Carolina - Medical Record Review states in order to provide consistent quality of care to members, WellCare of South Carolina conducts a review of contract practitioner office medical records using criteria based upon SCDHHS contractual requirements. Practitioners are provided results of the review and if the physician's overall review results are below 80%, a corrective action plan is issued and the provider is re-audited during the next cycle.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					WellCare conducted an annual MRR in 2017 and selected a random sample of 200 medical records from the most recent hybrid HEDIS season records; 100 Adult and 100 Child. Results for the Adult MRR Audit showed 100 providers passed the 80% goal with an average score of 93%. The lowest scoring element was due to lack of documentation regarding the following: demographics which requested information on Employment and Responsible Party followed by Medicaid Identification Number. No corrective action was identified. Results for the Child MRR Audit showed 99 providers passed the 80% goal with an average score of 93%. One provider failed the MRR audit with a score of 73% due lack of documentation regarding the following: Medicaid Identification Number, Immunization Status and Signature and Title of Provider (deficit for title

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation). Results from the follow-up of the 2016 MRR were received. Four providers failed the original audit and all four were re-audited with results showing they comply. The updated results were reported to the UMAC in the August 14, 2017 meeting.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy SC22-OP-CS-023, Medicaid Customer Service Disclosure of Rights and Responsibilities Policy, indicates WellCare educates staff on member rights through staff training and monitors call center staff to evaluate compliance with member rights. Members are informed of member rights at the time of enrollment via the Member Handbook. Providers are instructed on member rights via the Provider Manual or direct mail. Member rights are also found on WellCare's website.
2. Member rights include, but are not limited to, the right:	X					Member rights are consistently and appropriately documented in Policy SC22-OP-CS-023, the Member Handbook, the Provider Manual, and on WellCare's website.
2.1 To be treated with respect and with due consideration for his or her dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information including:	X					WellCare provides members with a Member Handbook no later than 14 calendar days from notification from SCDHHS of the member's enrollment. The Change Control Log on the WellCare website indicates any changes made to the Member Handbook.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						Onsite discussion confirmed WellCare covers substance abuse treatment services provided by DAODAS; however, the Member Handbook does not mention that substance abuse treatment services provided by DAODAS (and its subcontracted 33 county alcohol and drug abuse authorities) are covered.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the Member Handbook to include that substance abuse treatment services provided by DAODAS (and its subcontracted 33 county alcohol and drug abuse authorities) are covered.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						The Member Handbook defines copayment amounts and defines members who are exempt from copayment requirements. Copayment amounts are consistently documented in the Member Handbook, Provider Manual, and on the website.
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The Member Handbook provides an overview of the PA process and associated timeframes, and explains when PA is not required.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook provides information on after-hours, urgent, and emergent care.
1.7 Procedures for post-stabilization care services;						Brief information on post-stabilization care is provided in the Member Handbook.
1.8 Policies and procedures for accessing specialty/referral care;						
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The Member Handbook includes information on the pharmacy benefits manager (CVS/Caremark) as well as an overview of how to get prescription medications filled, applicable copayments, the preferred drug list, etc.
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The Member Handbook explains WellCare's process for assigning a PCP and provides information on how the member may select or change their PCP.
1.12 Procedures for disenrolling from the MCO;						
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook includes a thorough explanation of EPSDT services and well-child visits, and defines services included in an EPSDT exam as well as the schedule for recommended services for children from birth through 21 years old.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can receive assistance with executing an advance directive;						
1.22 Information on how to report suspected fraud or abuse;						
1.23 Additional information as required by the contract and by federal regulation;						
1.24 The MCO notifies each member, at least once per year, of their right to request a Member Handbook or Provider Directory.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Policy SC22-PD-002, Covered Service Policy, addresses notifying members at least 30 days prior to the discontinuation or modification of an additional service, but the policy does not address member notification of changes to the core benefits or services. Policy SC22-HS-UM-017, Continued Care with Terminated Provider and Notification to Member of Specialist Termination, describes the process for providing written notification of a provider's termination. Policy SC22-OP-EN-007, Member Notification of Specialist Termination, states WellCare makes a good faith effort to provide written notice of a contracted provider's termination within 15 days from the date of receipt or issuance of termination notice. This notice is provided to each member who was seen on a regular basis by the terminated provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise Policy SC22-PD-002, Covered Service Policy, to indicate members will be notified at least 30 days prior to discontinuation or modification of core benefits and services.
3. Member program education materials are written in a clear and understandable manner and meet contract requirements.	X					Policy SC22-SM-004, Medicaid Written Member Materials and Marketing Materials Review and Approval Process, indicates all materials are written at a grade level no higher than the 6th grade or as determined appropriate by SCDHHS. The policy does not define the methods used to determine the reading level. Onsite discussion confirmed WellCare uses the Flesh-Kincaid method. Policy SC22-SM-004, Medicaid Written Member Materials and Marketing Materials Review and Approval Process, states WellCare ensures appropriate foreign language versions of all materials are available. Foreign language versions of materials are produced when more than 5% of a county's population speaks a foreign language. *Recommendation: Revise policy SC22-SM-004, Medicaid Written Member Materials and Marketing Materials Review and Approval Process, to include the method(s) used to determine reading level of member materials.*
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					WellCare's Member Services Call Center is in SC. The toll-free telephone number for the Member Services Call Center is widely-publicized in member materials and on the website. WellCare's Member Services Call Center is available Monday – Friday from 8 am to 6 pm. The Nurse Advice Line is available 24 hours a day. The automated

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						greeting informs members to call 911 in case of an emergency, and prompts are available to allow callers to speak with the Nurse Advice Line or to leave a voicemail. Voicemail messages receive a response within one business day. Policy SC22-OP-CS-001, Medicaid Customer Service Requirements Policy, addresses: •Hours of operation, staffing, and personnel •Access and response standards—requirements include 80% of calls answered within 30 seconds, abandonment rate of 5% or less, no more than 2% of incoming calls receiving a busy signal, and an average hold time of 3 minutes or less •Monitoring of calls via recording or other means •Compliance with standards Translation services are provided by Voiance, and bilingual (Spanish-speaking) Member Services representatives are available at the Tampa Call Center.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy SC22-OP-EN-005, Disenrollment, defines requirements and processes for disenrollment.
III D. Preventive Health and Chronic Disease Management Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Members are informed of preventive health services and recommended schedules for those services in the Member Handbook. The Member Handbook also includes information on Disease Management programs available. WellCare sends reminder notices to members of upcoming and needed health screenings, preventive services, and dental screenings. In addition, Member Services and Case Management staff see care gap alerts in their documentation platforms to alert members to needed services. Disease Management Programs in the Member Handbook include Asthma, Diabetes, CAD, CHF, COPD, Hypertension, Smoking Cessation, and Weight Management. However, the Provider Manual and the Disease Management Program Description also include Depression as a Disease Management Program. The Member Handbook states depression is handled under the Case Management Program rather than the Disease Management Program. *Recommendation: Revise the Member Handbook to include depression as a Disease Management Program instead of a Case Management Program.*
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					Members are informed of the EPSDT program at the time of enrollment via the Member Handbook. Pregnant members are sent a letter informing them of the EPSDT program upon identification of their pregnancy or within 7 days after the baby's birth. Members who are past due for a child health screening are identified monthly via claims and encounter data—an AAP periodicity letter is mailed with education on the need to see their PCP. The periodicity letters are also sent during the member's birth month.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Various community events are held yearly to provide education on risk factors and wellness promotion. These are advertised via promotional flyers and radio ads. Attendance at these events is tracked.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					WellCare contracts with SPH Analytics, a certified CAHPS survey vendor to conduct the adult and child surveys. The survey response rates decreased from the previous year's survey. The Adult Survey response rate was 25% last year and fell to 17.7% this year. The Child Survey response rate was 18.6% last year and fell to 13% this year. This represents a decrease of 7% for the Adult Survey and over 5% for the Child Survey. The rates have continued to decline from 2015 to 2016 to 2017. *Recommendation: Continue working with SPH or other chosen vendor to increase response rates. Possible interventions for increasing response rates*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include adding reminders to call center scripts, placing a stamp on initial and follow-up mail outs, maximizing the oversampling, and allowing a longer timeline for additional reminders to be sent and phone call surveys to be conducted. CCME encourages WellCare to decide upon and document an internal goal to increase response rates (such as a 3% increase each year).
1.1 Statistically sound methodology, including probability sampling to ensure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					SPH Analytics summarizes and details all results from both the Adult and Child Surveys, and WellCare analyzes the vendor reports.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					Evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction are found in the CAHPS Analysis SC CAID 2017 and Medicaid Program 2016 Annual Evaluation documents.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO reports the results of the member satisfaction survey to providers.	X					At the time of the onsite visit, the 2017 CAHPS survey results had not been reported to the Providers; however, the results are included in the draft Provider Newsletter for Quarter 4 of 2017 which was provided after the onsite visit.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					QIC meeting minutes did not include a discussion of the full 2017 CAHPS results and actions plans based on those results. WellCare provided a presentation that included information on a work group that is in development to focus on CAHPS scores. In addition, a rapid cycle PIP is in progress to address CAHPS scores. The results will be presented during the next QIC meeting. *Recommendation: Ensure complete CAHPS results are presented to the QIC.*
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC22 OP-GR-001, Medicaid Grievance Policy, defines WellCare's processes for processing and resolving member grievances.
1.1 Definition of a grievance and who may file a grievance;	X					Policy SC22 OP-GR-001, Medicaid Grievance Policy, defines a grievance as, "An expression of dissatisfaction about any matter other than an action." The Member Handbook defines a grievance as, "a complaint about an issue that doesn't involve coverage or claims payments."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual defines a grievance as, "an expression of dissatisfaction about any matter other than an Action." *Recommendation: Replace the term "action" with the new term of "adverse benefit determination" throughout Policy SC22 OP-GR-001, Medicaid Grievance Policy, and the Provider Manual. Refer to the SCDHHS Contract, Section 9.1 (a).*
1.2 The procedure for filing and handling a grievance;		X				*Federal Regulation § 438.402 (c) (B) (4) (ii) (2)* and the *SCDHHS Contract, Section 9.1.1.2.1* allow a grievance to be filed at any time. The timeframe to file a grievance is appropriately documented in Policy SC22 OP-GR-001, Medicaid Grievance Policy, and the Provider Manual. However, page 50 of the Member Handbook and the WellCare website state grievances can be filed within 30 calendar days of the event that caused the dissatisfaction. *Quality Improvement Plan: Revise the Member Handbook and the website to reflect the correct timeframe for filing a grievance.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				Grievance resolution/notification timeframes and information on extensions of the timeframes are correctly documented in Policy SC22 OP-GR-001, Medicaid Grievance Policy, and the Member Handbook. The *SCDHHS Contract, Sections 9.1.6.1.5.1 and 9.1.6.1.5.2,* defines requirements for member notification when the health plan extends the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievance resolution timeframe. However, the Provider Manual and WellCare website do not address the requirement for oral and written notification to the member when the plan initiates an extension of the appeal resolution timeframe. The *SCDHHS Contract, Section 9.1.6.1.1*, requires grievances to be resolved no later than 90 calendar days from the date the grievance is received. However, The Grievance Acknowledgement Letter incorrectly states the grievance resolution and notification timeframe is within 60 days of receiving the grievance. *Quality Improvement Plan: Update the Provider Manual and WellCare website to indicate members will be notified orally and in writing when the plan initiates an extension of the grievance resolution timeframe. Correct the grievance resolution and notification timeframe in the Grievance Acknowledgement Letter.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The MCO applies the grievance policy and procedure as formulated.		X				Review of grievance files revealed: •In 2 files, the Notice of Resolution letters were sent beyond the allowed timeframe •For 3 files, Acknowledgement letters were sent after

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the allowed 5-business day timeframe •For 3 files, there was no evidence of Acknowledgement letters •For 2 files, additional information was requested in writing from the member. The Additional Information letters were not dated, but informed the members that the information was needed "within 10 days of the date of this letter". *Quality Improvement Plan: Ensure Acknowledgement letters and Resolution letters are sent within the required timeframes, that each grievance is acknowledged, and that Additional Information letters are dated.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievance information is retained for 10 years. Information includes the resolution, decision date, member name, Medicaid number, titles and credentials of those reviewing the grievance, all requests for documents/records, documentation of the grievance and investigation, and any actions taken to resolve the grievance. Grievance data is reported as required to SCDHHS. Grievances are reported monthly, quarterly, and annually to WellCare management. The data are analyzed to identify issues and trends, and reported to the Customer Service Quality Improvement Workgroup (CSQIW), the UMAC, and the QIC.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					WellCare's 2017 Medicaid QI Program Description describes the structure, resources and processes used for measuring and improving the care and services. The program description outlines the QI program goals, objectives and the program's scope. The UMAC, QIC and the Board of Directors review and approve the Program Description.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					The QI Program Description does not address monitoring provider compliance with clinical practice guidelines and preventive health guidelines. However, Policy SC22 HS-QI-009, South Carolina – Provider Clinical Practice Guidelines and Preventive Health Guidelines addresses annual monitoring. During the onsite, WellCare provided CCME with a sample of the monitoring they conducted. *Recommendation: Include the monitoring of provider compliance with clinical practice guidelines in the QI Program Description and in the work plan.*
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					WellCare's Annual Work Plan identifies specific activities and projects underway. The Work Plan is updated frequently and provided to the QIC quarterly.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					WellCare's Board of Directors delegates the authority to approve specific QI activities to the QIC. Oversight of all clinical quality improvement, utilization management and behavioral health activities is the primary responsibility of the UMAC.
2. The composition of the QI Committee reflects the membership required by the contract.	X					WellCare's Medical Director, Dr. Robert London, chairs the QIC and the UMAC. Membership for the QIC includes senior leadership and other health plan directors and managers. The UMAC membership includes network providers whose specialties include pediatrics, family medicine, OB/GYN, cardiology and behavioral health. Network provider attendance is poor. In 2016 WellCare had eight network providers represented on the UMAC and nine for 2017. CCME reviewed meeting minutes WellCare provided (August 2016 – June 2017). For the August 2016 meeting, four network providers attended the meeting and for November 2016, three. For the February 2017 and June 2017 meetings, three network providers attended. WellCare defines a quorum for the UMAC as at least three voting members, two external physicians and the Medical Director. In the event of a tie vote, the chairperson is the tie-breaker. The Medical Director serves as the chairperson for this committee and is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						also listed as a voting member. *Recommendation: Change the quorum requirements for the UMAC so the chairperson/Medical Director is not considered the tie breaker or a voting member.*
3. The QI Committee meets at regular quarterly intervals.	X					Both committees meet at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes reviewed were well documented.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					WellCare uses Quality Spectrum Insight (QSI) by Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements. The comparison from the previous to the current year revealed a strong increase in follow up after hospitalization for mental illness for both the 30-day and 7-day rates. The measures that decreased substantially are Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) and Statin Therapy for Patients with Cardiovascular Disease (spc), Statin Adherence at 80%. *Recommendation: Evaluate changes in rates that are not going in the intended direction, and develop and document specific quality improvement plans to increase or decrease rates as intended.*
IV D. Quality Improvement Projects						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					CCME validated two projects using the CMS Protocol for Validation of Performance Improvement Projects. They included Access to Care and Improving Hemoglobin A1C Testing.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Both projects scored within the High Confidence Range. There was one recommendation made last year regarding the Improving Hemoglobin A1C Testing PIP, which was to include the personnel and their qualifications in the report. This recommendation was carried out and those elements were included in this year's report for that PIP. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Network providers are contractually required to comply with WellCare's QI Program which includes providing member records for assessing quality of care. Providers are invited to volunteer for participation in the QI Program. Avenues for participation include committee representation, quality/performance improvement projects, EPSDT assessments and feedback/input via satisfaction surveys, grievances, and calls to Provider Services. Provider participation in quality activities helps support integration of service delivery and benefit management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					At least annually the QI Department supports a formal evaluation of the effectiveness of the program. The 2016 Medicaid QI Program Evaluation was provided.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					The QI annual evaluation is presented to the QIC and the Board for final approval and recommendations. This was evident by the approval dates documented in the evaluation.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The 2017 Utilization Management (UM) Program Description is specific to the SC Medicaid Managed Care product, and was last reviewed and approved by the UMAC and QIC in March and April 2017. The UM Program Description provides an overview of the structure and operations of the UM Department, and includes the program's purpose, goals, scope, and lines of authority within the department. Departmental policies provide more detailed information on the program's functions, requirements, and processes.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					Lines of responsibility and accountability are well-defined in the UM Program Description.
1.3 guidelines / standards to be used in making utilization management decisions;	X					Criteria used in medical necessity decision making are specified in Policy SC22 HS-UM-011, Application of Criteria.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The following issues were noted in Policy SC22 HS-UM-025, Service Authorization Decisions Policy: •Page 3 does not indicate the member's authorized representative can request an extension of the standard determination timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Page 6 does not include that the provider or authorized representative can request an extension of the standard determination timeframe. •Page 3 references a 3-business day timeframe for expedited authorization determination. All other documentation correctly states the expedited determination timeframe of 72 hours (or 3 calendar days). *Quality Improvement Plan: Revise page 3 of Policy SC22 HS-UM-025 to indicate the member's authorized representative can request an extension of the standard determination timeframe); revise page 6 of Policy SC22 HS-UM-025 to include that the provider or authorized representative can request an extension of the standard determination timeframe; and revise page 3 of Policy SC22 HS-UM-025to correct the timeframe for expedited authorization determinations.*
1.5 consideration of new technology;	X					As defined in Policy SC22-HS-UM-009, New Medical Technology Assessment, WellCare's UMAC evaluates and addresses new developments in technology and new applications of existing technology for possible inclusion in WellCare's benefit plan to ensure members have access to safe and effective care. Recommendations are made to the QIC. Requests for services for which there are no available criteria are reviewed by a Medical Director for authorization determinations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					The 2017 Preferred Provider Program Description provides detailed information on WellCare's "Gold Card" Program, developed to meet the requirements of the *SCDHHS Contract, Section 8.5.2.8*. Providers are identified for the Gold Card/Preferred Provider Program by using quality and cost metrics.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					WellCare conducts ongoing monitoring and evaluation of the UM Program and develops a formal, written evaluation annually. The UMAC and QIC review the UM Evaluation to assess objectives, scope, implementation, organization, and effectiveness of the UM Program. The UM Evaluation is used as the basis for the following year's Work Plan. As described in Policy SC22 HS-UM-011, Application of Criteria, the Medical Director, Medical Advisory Committee, and QIC review and approve medical necessity criteria annually. Onsite discussion confirmed network providers participating in the UMAC provide advice and input on the criteria being reviewed for approval.
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Approved files reflected use of appropriate criteria and requests to obtain additional information when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Processes and requirements for coverage of hysterectomy, sterilization, and abortion procedures are specified in Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions, the Member Handbook, and the Provider Manual. As specified in the *SCDHHS MCO Policy & Procedure Guide, Section 4.2.27*, the correct form number for the Sterilization Consent Form is SCDHHS Form HHS-687. The following issues were noted: •Page 2 of Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions, item B (2) (g), lists the Sterilization Consent Form as SCDHHS Form 1723. •Page 64 of the Provider Manual lists "OHHS 1723" as the Sterilization Consent Form number. •The Sterilization Consent Form available on WellCare's website is the SCDHHS Form 1723. Additional issues noted in Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions include: •Page 1 contains an incorrect reference to the *SCDHHS Contract, Section 4.2.28*. The correct reference is Section 4.2.27. •Page 2 contains two references to the *SCDHHS MCO Policy and Procedure Guide, Section 4.1.1*. The correct section is 4.2.1. •Page 2, item C (1), states, "WellCare shall perform abortions..."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Page 3, item C (1) (a) (i) contains an empty table. *Recommendation: Update the Sterilization Consent Form number in Policy SC22-HS-UM-030 and the Provider Manual. Update the website to provide the correct Sterilization Consent form. Update the specified references to the SCDHHS Contract and the SCDHHS MCO Policy and Procedure Guide in Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions. Correct the incorrect statement that WellCare performs abortions on page 2 and update or remove the empty table on page 3 of Policy SC22-HS-UM-030.*
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy SC22-HS-UM-007, Interrater Reliability, defines WellCare's process for annual inter-rater reliability (IRR) testing of all licensed reviewers who issue medical necessity determinations. IRR results are reported to the UMAC and QIC annually.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.		X				Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services, describes requirements and processes for coverage of emergency and post-stabilization services. The Policy does not include the following requirements: •That WellCare will "not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." Refer to the *SCDHHS Contract, Section 4.2.11.1.8* and *Federal Regulation § 438.114 (c) (ii) (A)*. •That WellCare will "Limit charges to members for any post-stabilization care services to an amount no greater than what the charges would be if the member had obtained the services through an in-network provider. Refer to the *SCDHHS Contract, Section 4.2.11.2.6.* The Provider Manual and Member Handbook provide information regarding emergency and post-stabilization services. *Quality Improvement Plan: Revise policy SC22-HS-UM-028, Emergency and Post-Stabilization Services, to include the requirements specified in the SCDHHS Contract, Sections 4.2.11.1.8 and 4.2.11.2.6.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
8. Utilization management standards/criteria are available to providers.	X					Policy SC22 HS-UM-011, Application of Criteria, defines processes followed when members or providers request criteria used to render a determination of medical necessity.
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Approval files reflected timely determinations and notification of the determinations.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.		X				Issues noted with documentation in the Notice of Adverse Benefit Determination letters include: •One letter stated the criteria used for the review was "medical literature" but did not include the citations of the actual literature reviewed, and did not include the initially-reviewed InterQual criteria set. •Two letters specified the articles reviewed by the physician reviewer, but did not include the initially-reviewed InterQual criteria set. *Quality Improvement Plan: Ensure that the criteria*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						used to formulate a denial determination are included in the Notice of Adverse Benefit Determination letters.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					The following policies address member appeals: •SC22 HS-AP-002, Member Appeals Policy •SC22-RX-012, Pharmacy Appeals •SC22-OP-CS-024, Medicaid Customer Service Intake of Member Appeals Page 1 of Policy SC22-OP-CS-024, Medicaid Customer Service Intake of Member Appeals, states, "The Company's Customer Service Department will strictly adhere to the "Appeals Workflow" requirements outlined in this policy and ensure members' issues are resolved in a timely manner." However, no appeals workflow documentation could be found in this Policy. The Policy contains only definitions of appeals-related terms. *Recommendation: Revise Policy SC22-OP-CS-024 to include the referenced appeals workflow or remove the reference to the workflow.*
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Terms related to appeals are appropriately defined in Policy SC22 HS-AP-002, Member Appeals Policy, Policy SC22-RX-012, Pharmacy Appeals, and the Provider Manual. Policy SC22-OP-CS-024, Medicaid Customer Service Intake of Member Appeals, uses the term "action" which should be "adverse benefit determination," and is missing part of the definition of an adverse

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						benefit determination. Refer to the *SCDHHS Contract, Section 9.1 (b) (vii).* *Quality Improvement Plan: Revise Policy SC22-OP-CS-024 to use the term "adverse benefit determination" instead of "action" and to include the complete definition of an adverse benefit determination specified in the SCDHHS Contract, Section 9.1 (b).*
1.2 The procedure for filing an appeal;		X				Onsite discussion confirmed the timeframe to file an appeal is 60 calendar days from the date printed on the Notice of Adverse Benefit Determination letter. However, the following items define the timeframe to file an appeal as 60 calendar days from receipt of the notice of adverse benefit determination: •Pages 5, 6 and 12 of Policy SC22 HS-AP-002, Member Appeals Policy •Page 93 of the Provider Manual •The Initial Adverse Benefit Determination letter (medical necessity) (state-approved on 7/5/17) Policy SC22-RX-012, Pharmacy Appeals, is not specific to SC requirements. •Page 8 states the appeal request must be filed within the requested timeframe per State, from the date of the Notice of Adverse Benefit Determination (i.e., the date printed or written on the notice). •Page 20 states 60 days, but does not indicate when the 60-day period begins. Policy SC22-RX-012, Pharmacy Appeals, does not address the requirement of aiding members in the appeals process, and page 11 of the Policy states WellCare sends an Acknowledgment letter to the member and the requestor within the required timeframe specified by each State, but does not

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specify the actual timeframe for acknowledging receipt of the appeal. *Quality Improvement Plan: Correct the timeframe to file an appeal in Policy SC22 HS-AP-002, Member Appeals Policy, the Provider Manual, and the Initial Adverse Benefit Determination letter (medical necessity) (state-approved on 7/5/17). Revise Policy SC22-RX-012, Pharmacy Appeals, to address appeal acknowledgement and to include specific South Carolina requirements for appeals. Alternatively, consider retiring this policy and including information on pharmacy appeals in Policy SC22 HA-AP-002.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Requirements for appeal resolution and notification timeframes are appropriately documented in Policy SC22 HS-AP-002, Member Appeals Policy, the Member Handbook, and the 2017 Initial Adverse Benefit Determination letter. Issues regarding documentation of appeal resolution and notification timeframes include: •Page 20 of Policy SC22-RX-012, Pharmacy Appeals, states the standard appeal resolution timeframe is 30

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						days but does not define when that 30-day timeframe begins (i.e. from the receipt of the appeal request). •Page 20 of Policy SC22-RX-012, Pharmacy Appeals, states the expedited appeal resolution and notification timeframe is 72 hours but does not define when that 72-hour timeframe begins (i.e. from the receipt of the appeal request). •Policy SC22-RX-012, Pharmacy Appeals, does not address the timeframe for written notice to the member of the plan's denial of expedited processing for an appeal. •Extensions of standard and expedited appeal resolution timeframes are not addressed in Policy SC22-RX-012, Pharmacy Appeals. •Page 95 of the Provider Manual indicates the expedited appeal resolution and notification timeframe is 72 hours, but does not define when the timeframe begins (i.e. from receipt of the appeal request). *Quality Improvement Plan: Revise Policy SC22-RX-012, Pharmacy Appeals, to include the missing information specified above. Alternatively, consider retiring this policy and including information on pharmacy appeals in Policy SC22 HA-AP-002. Revise page 95 of the Provider Manual to clearly define the expedited appeal resolution and notification timeframe as 72 hours from receipt of the appeal request.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO applies the appeal policies and procedures as formulated.	X					
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the UMAC and QIC. Onsite discussion confirmed that pharmacy appeals data is also reported to the UMAC and QIC; however, this is not documented in Policy SC22-RX-012, Pharmacy Appeals. Review of UMAC minutes for 6/2017, 2/2017, 11/2016, and 8/2016 confirmed review and discussion of appeals metrics. *Recommendation: Update Policy SC22-RX-012, Pharmacy Appeals to indicate pharmacy appeals data is reported to the UMAC and QIC.*
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The 2017 Care Management Program Description provides an overview of the Care Management Program, defines the purpose, objectives, scope, and structure of the program, and includes information on Case Management (CM) operations, processes, and key performance indicators. CM policies have been developed to provide further detail on CM processes and requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from case management.	X					The Care Management Program Description specifies methods of identifying members who may benefit from CM services. Among those methods are data mining and risk stratification; direct referrals from practitioners, community programs, state agencies, the Nurse Advice Line, the Crisis Line, UM staff, discharge planners, and member/caregiver self-referral. WellCare also uses a risk stratification model to identify and stratify members who may benefit from case management services.
3. The MCO provides care management activities based on the member's risk stratification.	X					Page 14 of the Care Management Program Description provides brief information on risk stratification but does not define the CM services provided to each of the acuity levels. CCME could not find this information in CM policies. Onsite discussion revealed low-risk members are provided educational materials; moderate risk members receive telephonic CM services, and high-risk members receive field CM services. *Recommendation: Define the Case Management services provided to each of the acuity levels (low, moderate, and high-risk) in either the Care Management Program Description or in a CM policy.*
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					The Care Management Program Description, provides an overview of field-based and telephonic medical and behavioral CM services to ensure a holistic approach to member care and to promote positive clinical outcomes. Local cross-functional teams partner with schools, state agencies, and community-based organizations to reach and engage with members and facilitate access to care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Focused CM Assessments are conducted within 30 days of identification or referral to CM to aid in the development of an individualized care plan to address the member's needs and assist the member to reach optimal wellness. The Care Management Program Description addresses referrals for Targeted Case Management services for diagnoses of Serious Emotional Disturbance and Seriously Mentally Ill/Serious and Persistent Mental Illness, but does not address Targeted Case Management referrals for: •alcohol/substance abuse •children in foster care and in the juvenile justice system •sensory impaired individuals •individuals with mental retardation or a related disability •individuals with head/spinal cord injury or a related disability •children and adults with sickle cell disease •adults in need of protective services Onsite discussion confirmed referrals for Targeted Case Management for these diagnoses and that these diagnoses are included in a "step-action" (desk procedure) document. *Recommendation: Revise the Care Management Program Description to include the full list of diagnoses for which Targeted Case Management referrals are made.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy SC22-HS-UM-019, Care Coordination Continuity and Transition of Care Policy, and Policy SC22-HS-CM-017, CM Transition to Other Care Process, address transition of care.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements	X					Susan Martinez serves as WellCare's Transition Coordinator.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The CM Department continuously monitors and evaluates the quality and effectiveness of the program structure and processes for opportunities for improvement. Policy SC-22 HS-CM-009, Customer Satisfaction Survey, defines the process for conducting Member Satisfaction Surveys for members who are/have been enrolled in WellCare CM or Disease Management Programs.
7. Care management and coordination activities are conducted as required.	X					Case Management files revealed thorough case notes, evidence of transitional CM, member opportunities to complete Member Satisfaction Surveys, and multiple attempts to contact members after unsuccessful attempts.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Policy SC22-HS-UM-006, Under and Over Utilization of Services, addresses monitoring and analysis of relevant data and actions to correct any patterns of potential over and underutilization.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					As noted in the 2016 SC Medicaid Utilization Management Program Evaluation and UMAC meeting minutes, WellCare analyzed and monitored data, and offered recommendations based on findings for several services regarding utilization. WellCare analyzes data on the following utilization topics: •Behavioral Health Residential Admits •Behavioral Health Inpatient Readmits •Medical Inpatient Readmission •Inpatient Admits per 1000 •Length of Stay

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all subcontractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					WellCare has written agreements with all entities performing delegated services. Many of the delegations are corporate contracts that provide support to WellCare; addendums define any state specific contract requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						WellCare delegates the following services: •UM – Advanced Medical Review; CareCore National, LLC d/b/a EviCore Healthcare; Health Help, LLC; Progeny Health, Inc. •UM Behavioral Health – Focus Health •Nurse Advice Line – CareNet •Pharmacy – CVS •Customer Service –Teleperformance; The Results Companies; SPH Analytics •Crisis Line – Health Integrated, Inc. •Case Management (OB and High-Risk Pregnancy) – Alere •Vision – March Vision •Credentialing – AU Medical Center (MGC Health, Inc.); Greenville Hospital System; Integra Partners, IPA; Linkia, LLC; Mary Black Health Network Inc.; Medical University Hospital Authority; Minute Clinic; Preferred Care of Aiken, Inc.; Regional Health Plus LLC; Roper St. Francis Healthcare (CareAlliance Health Services); St. Francis Physician Services; Take Care Clinics; United Physicians, Inc. (formerly Provider Healthlink of South Carolina, LLC)
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				The Delegation Oversight Committee coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory and accreditation requirements. The committee includes corporate and plan representation and the Director of Health Services Delegation Oversight chairs the committee. The Director of Quality Improvement from SC, is a member of the committee. This committee reports to the QIC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC22 CP-AO-007 SC – Delegation Oversight, and Procedure SC22-CP-AO-007-PR-001 define the process for evaluation and oversight of delegated entities to ensure compliance of the delegated functions. Both the policy and procedure incorrectly reference Procedure SC22 HS-CR-001-PR-001 which was retired and merged with Policy SC22 HS-CR-001. WellCare's detailed process of oversight for delegated entities includes annual oversight, and monthly and/or quarterly data review with corrective action as appropriate. WellCare uses scorecards that are tailored to each market/line of business and address federal, state and accreditation requirements. CCME received proof of oversight activities for all delegated entities. CCME identified these issues: •Greenville Health System- The credentialing file review tool showed "Y" that Ownership Disclosure forms (ODF) were present in all the files, but "N" they were not compliant. The recredentialing file review tool showed the ODF's were "N" not present but "Y" were compliant. This information is inconsistent. It does not appear that Greenville Health System collects ODFs for recredentialing. •AU Medical Center (MGC Health, Inc.) – These are Georgia providers that see SC patients. The credentialing and recredentialing file review tools showed "N/A" for ODFs and CLIAs. The global credentialing tool stated N/A for SC requirements with the statement, "N/A providers are credentialed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						in Georgia and can see South Carolina patients Attachments Required Comments. Required N/A providers are credentialed in Georgia and can see South Carolina patients." WellCare needs to ensure that SC credentialing requirements are followed for all providers that see SC members. •Mary Black Health Networks, Inc. – The global review tool indicated there was no policy for review of Ownership Disclosure form 1514 upon initial credentialing, re-credentialing or ownership changes. The comment made by the reviewer was, "compliant – this is sufficient since it is a new requirement and will be verified post implementation." All credentialing and recredentialing files reviewed showed N/A for ownership disclosure and for CLIA. The complete date for this review was 12/6/16 and this was not a new requirement. •Minute Clinic – The global review tool indicated they do not obtain CLIA certificates for their individual providers because the certificate is obtained at the practice level. However, for all providers that are performing laboratory services a copy of the CLIA must be in the file. This includes if the provider works for a practice. A copy of the practice CLIA needs to be in the file. •Take Care Clinics – The global review tool indicated "No" in #1-135 for the delegated entity doing business in SC and shows N/A for all the SC requirements. The file review tool showed GA providers reviewed with N/A for SC requirements. However, the Annual Audit Results letter showed that

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC Medicaid was included in the review. •St. Francis Physician Services - The global review tool #161-162 shows the entity attached the Ownership Disclosure form; however, the auditor indicated N/A and stated, "Entity not currently delegated for Medicaid; Individual Practice ODF's submitted with credentialing files; N/A." However, the Oversight Results letter stated a pre-delegation audit for the SC Medicaid lines of business was conducted. During onsite discussion WellCare indicated additional training may be needed for employees that conduct delegation oversight reviews. *Quality Improvement Plan: Update Policy SC22 CP-AO-007 and Procedure SC22-CP-AO-007-PR-001 to remove the incorrect references to Procedure SC22 HS-CR-001-PR-001. Address issues identified in the oversight documents such as inconsistent or incomplete information; ensure out-of-state providers (i.e. Georgia) that see SC members are credentialed/recredentialed to SC requirements; ensure Ownership Disclosure forms and CLIA certificates are collected as required.* *Recommendation: Consider implementing an internal spot-check process for WellCare employees conducting delegation oversight reviews to identify training issues in the delegation oversight process.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V II. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					WellCare educates providers about the EPSDT program through the Provider Manual, when contracting with WellCare, during provider relations orientation sessions, and annually. Monthly membership lists of children who have not had an encounter within 120 days of joining the plan or who are not following the EPSDT Program are distributed to providers. The providers are responsible for monitoring, tracking, and following up with members who have not had a health assessment screening, and those who miss appointments for ESPDT services. Providers are also to ensure members receive appropriate referrals to treat any conditions or problems identified during the health assessment to follow-up to ensure they receive the necessary medical services. WellCare assesses providers' compliance with member monitoring, tracking, and follow up through random QI Department Medical Record Review (MRR) audits. The plan gives providers written notification of the audit results, contact information for clarification if needed, and access to a quality practice manager. WellCare automatically selects providers who do not successfully pass the MRR for another MRR during the subsequent review cycle.
1.2 performing EPSDTs/Well Child Visits.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					